The Journal of the American Medical Association

Published Under the Auspices of the Board of Trustees

VOL. 132, NO. 17 — CHICAGO, ILLINOIS — DECEMBER 28, 1946

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CONTRACEPTION MASKING STERILITY AND INFERTILITY

Tubal and Seminal Factors in 1,000 Cases

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In the many years since contraception was first ventured on as a topic for discussion at medical meetings, I have had occasion to call attention to the fact that this practice would inevitably be resorted to by some—perhaps by many—married couples who were actually or potentially infertile. This observation was based on early work with uterotubal insufflation, in which several women who had used contraceptive methods proved to have a pathologic barrier to conception in the tubes which rendered preventive measures actually unnecessary. The barrier might well have been present at the time of, or shortly after, marriage and was incidentally masked by the contraceptive practice.

Many similar cases have since come under personal observation in a large number of women who have sought relief for primary sterility. But this difficulty has not been confined to childless women. There were an increasing number of women who, having employed contraception for varying lengths of time after one childbirth or after one or several spontaneous or induced abortions, decided to try to become pregnant again and were chagrined at their failure. Apparently something had happened in the interim to render the woman, or rather the couple, less fertile.

A question that naturally arises is to what extent, if any, contraception actually impairs the chances of future conception. This is difficult to determine except from large statistical analyses which are as yet unavailable. Since contraception is so commonly practiced, it would be of value to find a trustworthy statement recorded in each obstetric history as to the method and duration of the practice with respect to past and present pregnancies. In the future, this item should be included in all obstetric histories. It would give data that could throw much light on the question of possible deleterious effects of contraception. As far as I am aware, this aspect has not heretofore been adequately studied. However, in a recent publication [1] I took occasion to note the interval of time elapsing between the cessation of contraception and the onset of pregnancy in 590 women who became gravid after treatment for sterility. One hundred and ninety of the 590 women had used contraceptive precautions at some time during their married life. In 97, a little over half, an interval of at least two years had elapsed since they stopped contraception. Fifty-four, approximately one third, had not used precautions for three to seven years before they consulted their physician. Only one fifth of this group (39 patients) had ceased the use of precautions for one year before insufflation and before they became pregnant. Although these statistics are based on a small group of patients they nevertheless indicate the fact that an appreciable number of couples resort to contraception needlessly, because they are potentially infertile for varying lengths of time or have sterility factors which may or may not be amenable to corrective treatment.

As contraception is closely related to sterility, the methods and duration of this practice are matters which have received particular attention in the medical history of sterile women. But here too, although possibly it has an important etiologic relationship, the fact is not universally recorded. In my own practice this item had not previously been systematically taken into account, but it has become more and more a matter of routine questioning in the past ten years. In the last 1,000 consecutive cases of sterility on which the present study is based, there were only 33 histories without reference to contraception in the primary sterility group and 59 in the secondary sterility group. The omission of this reference in the medical history emphasizes, in general, the importance of complete statistical data. However, the data presented in these 1,000 cases give a fair estimate of the sterility factors in a group that did not practice contraception and in one in which contraception was resorted to for varying lengths of time.

It is not the purpose of this paper to enter into the pros and cons of the unfavorable influence of contraception on fertility but, rather, to call attention to the fact that many couples are obviously employing contraceptive precautions needlessly. Moreover, the important fact is that by so doing they lose much valuable time, if they desire to have children at any period of their married life. I am not concerned with couples who are unalterably opposed to offspring for special reasons of their own, although every one knows of instances in which there has been a change of heart in this respect. Some of these people present pathetic and tragic figures when they ask for help which is no longer available. If they had been aware from the onset of the possibility of hopeless infertility, it is not unlikely that a large number would have foresworn contraception in favor of seeking medical help to improve their chances to have a family.

In the present paper my records of the last 1,000 consecutive cases of sterility have been analyzed to determine to what extent reproductive stigmas were

Dr. Zakin was aided by the Dr. Hiram N. Vineberg grant in Gynecology.
Read before the Section on Obstetrics and Gynecology at the Ninety-Fifth Annual Session of the American Medical Association, San Francisco, July 4, 1946.
1. Rubin, I. C.: Therapeutical Aspects of Uterotubal Insufflation in Sterility, Am. J. Obst. & Gynec. **50**: 621-640 (Dec.) 1945.

present in the group of women who practiced contraception as compared to the group who did not use contraception. There were 711 cases of primary sterility and 289 cases of secondary sterility. As the problems are somewhat different in these two general groups, the etiologic factors have been tabulated separately.

Although the tubal factor was first considered in connection with the question of contraception and potential infertility, it was deemed desirable to consider several other deterrent factors in the same connection.

The cases are discussed under the classifications of primary and secondary sterility. In the primary sterility group are included women who have never conceived; in the second sterility group, women who have been pregnant once or several times. As a rule in the latter group the conception had terminated in abortion, ectopic pregnancy or stillbirth. Some had had an only child.

TABLE 1.—*Contraceptive Data*

	Primary Sterility, 678 of 711 Cases		Secondary Sterility, 230 of 289 Cases	
	1. Contraception Employed in 466 Cases	2. Contraception Not Employed in 212 Cases	3. Contraception Employed in 120 Cases	4. Contraception Not Employed in 110 Cases
A. Pelvic organ abnormalities	(466 cases examined)	(212 cases examined)	(120 cases examined)	(110 cases examined)
Hypoplasia	32	6	..	1
Fibroid uterus	26	10	6	7
Cervical stenosis	21	21	7	7
Retroversion	19	7	2	1
Cervical wick	9	3	3	2
Adnexal mass	6	..	2	2
Infantile cervix	6	2	..	..
Miscellaneous	14	10	1	8
Total	133 (28.5%)	59 (27.8%)	21 (17.5%)	28 (25.5%)
B. Endocrine dysfunction	(466 cases examined)	(212 cases examined)	(120 cases examined)	(110 cases examined)
Menstrual absence or irregularity	19	21	4	2
Hypothyroidism	15	2	2	1
Total	34 (7.3%)	23 (10.8%)	6 (5.0%)	3 (2.7%)
C. Seminal inadequacy				
(a) By Huhner test	(323 cases examined)	(127 cases examined)	(72 cases examined)	(57 cases examined)
Azoospermia, necrospermia or decided oligospermia	163 (50.5%)	63 (49.6%)	39 (54.3%)	19 (33.3%)
(b) By jar specimen	(199 cases examined)	(78 cases examined)	(43 cases examined)	(35 cases examined)
Azoospermia, necrospermia or decided oligospermia	92 (46.2%)	46 (59.0%)	22 (51.2%)	11 (31.4%)
D. Tubal impairment	(353 cases examined)	(162 cases examined)	(85 cases examined)	(81 cases examined)
Nonpatency	75	41	13	24
Stricture or adhesions	70	20	19	13
Spasm	37	8	8	3
Total	182 (51.6%)	69 (42.6%)	40 (47.1%)	40 (49.4%)
E. Etiologic factors summarized				
Pelvic organ abnormalities	133	59	21	28
Endocrine dysfunction	34	23	6	3
Seminal inadequacy (Huhner)	163	63	39	19
Tubal impairment	182	69	40	40
Times	512 (in 374 couples or 80.3%)	214 (in 72 couples or 81.1%)	106 (in 83 couples or 69.2%)	90 (in 77 couples or 70.0%)

PRIMARY STERILITY

In the primary sterility series there were 466 couples who had employed contraception during the first part of married life and 212 couples who had natural intercourse throughout marriage. Information in regard to contraception was lacking in 33 cases. Included are data on 27 women who had been married twice; contraceptive data related only to their present marriage are considered.

In the examination of the records of the 466 couples who had employed contraception, the major sterility factors were deduced from a simple workup. This consisted of physical examination of the wife and husband, uterotubal insufflation, examination of semen and determination of the basal metabolic rate when indicated.

The etiologic factors comprised four categories: (1) abnormality of the pelvic organs, (2) endocrine dysfunction, (3) seminal inadequacy and (4) tubal impairment. Bimanual examination, with routine use of the vaginal speculum, sufficed in practically all instances to determine the presence or absence of gross pelvic abnormalities which might have an etiologic bearing on the infertility. In a few instances hysterography was used. The evaluation of endocrine dysfunction was limited in this study to consideration of: (*a*) ovarian dysfunction as manifested by amenorrhea, hypomenorrhea, oligomenorrhea, menorrhagia and metrorrhagia or combinations thereof and (*b*), more specifically, hypothyroidism, as demonstrated by a diminished basal metabolic rate.

In most instances, an evaluation of the semen was derived from the Huhner test. When necessary, the diagnosis of seminal inadequacy was checked by examination of one or several samples of semen brought in a small glass container. The tubal status was determined by kymographic uterotubal insufflation with carbon dioxide gas (Rubin test).

Abnormalities of Pelvic Organs.—Abnormalities of the pelvic organs or diseased conditions capable of diminishing fertility were found in 133 women (28.5 per cent). As shown in table 1*A*, the most frequent abnormalities were uterine hypoplasia, uterine fibromyomas, cervical stenosis and uterine retroversion. The 26 women with fibroid tumors presented a surgical problem in which the question of uterine myomectomy versus hysterectomy had to be considered. In a number of them fibroid tumors had developed of such size and distribution as to indicate hysterectomy. Most of the women were 30 or more years of age.

Endocrine Dysfunction.—There were 19 women with menstrual difficulties and 15 with hypothyroidism, making a total of 34, or 7.3 per cent, with endocrine

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dysfunction (table 1 *B*, column 1). Had a more exhaustive study of endocrine stigmas been undertaken, the percentage might have been higher. Endocrine stigmas in the male have not been specifically investigated.

Seminal Inadequacy.—In evaluating seminal inadequacy, I struck a snag which is appreciated by every one who has endeavored to define what is normal or adequate seminal output and composition and what is abnormal. I have tried to get an idea of normal semen by studying the results of the Huhner test and the unmixed specimen in 83 cases in which pregnancy was recorded in the followup of the present series.

By the Huhner test only an approximate estimate may be made as to the number of spermatozoa deposited in the vagina, because they are clouded by epithelial cells in most specimens. For the same reason they are not amenable to determination in the counting chamber. It has therefore been customary to get an approximate estimate of the numbers of spermatozoa present by counting them in the high power microscopic field. In this study the unmixed specimen of semen has been estimated in the same way. I have attempted by a formula to convert the number of spermatozoa as seen in the high power field into the number per cubic centimeter, but the results have been too divergent for reliance. However, I have been impressed by the fact that in an appreciable number of cases the Huhner test showed 10 spermatozoa or less per high power field, despite which pregnancy has taken place.

These observations lead to the conclusion that an estimate of the potential fertility of the male cannot be based solely on the number of spermatozoa found in the vaginal or cervical secretions. As to a specimen brought in a glass container, one can only determine an approximate total of sperm content and note morphologic characteristics. As long as one cannot recognize definitely the particular type of spermatozoa which ultimately fertilizes the ovum, one cannot be sure which specimen may or may not be adequate for fertility. In the absence of such precise criteria, one nevertheless recognizes azoospermia and extreme degrees of oligospermia as unmistakable causes of male sterility. Absence of spermatozoa by the Huhner test, even if found on several occasions, is not always conclusive evidence of male sterility. Normal spermatozoa may be demonstrable in the specimen of semen itself. Bimanual examination and that with the speculum enable one to determine whether intromission of the penis into the vagina is anatomically possible. If the vagina appears normal in this respect, hypospadias, other penile defects or impotence is to be looked for in the husband. Apparently absence of motility of the spermatozoa in the vaginal or cervical secretions, or in both, one or two hours after coitus is not an absolute index of infertility, because 47 of 101 women in this series have become pregnant despite repeated evidence of nonmotility.

In many cases, however, the satisfactory nature of the semen could be determined by finding adequate numbers of motile spermatozoa in the vagina and cervix. In negative and doubtful cases the jar specimen of semen was examined. Of 199 such samples of semen, 92 (46.2 per cent) were inadequate due to azoospermia or definite oligospermia (table 1 *C*, column 1).

Tubal Impairment.—Tubal impairment was noted (*a*) when the tubes were nonpatent, (*b*) when they showed diminished patency and function due to tubal stricture or peritubal adhesions and (*c*) when the tubes were spastic.

In the group of 466 women with primary sterility who practiced contraception, the tubal status was determined in 353 cases: 182 (51.6 per cent) showed evidence of tubal impairment; 75 (21.3 per cent) had nonpatent tubes by several tests; 70 (19.8 per cent) partially patent tubes, and 37 (10.5 per cent) spastic tubes (table 1 *D*, column 1). Thus, without attempting to draw specific differences relative to voluntary and involuntary sterility, the fact remains that over 50 per cent of the women tested in this series who practiced contraception were handicapped by tubal nonpatency or impaired tubal function. In how many instances this obtained at the time of marriage and to what extent it was acquired after marriage is conjectural. There was a lack of important data in the records to clarify this point.

Infertility Factors.—In the group of 466 couples complaining of primary sterility, important factors were found a total of 512 times (table 1 *E*, column 1). In most of the couples under investigation only one causal factor was present; in others there were two or three causal factors. The total number of couples having one or more factors was 374 (80.3 per cent). It should be emphasized that the high incidence of sterility factors found in this analysis may be due in part to the fact that many of the cases either had been of long standing or had proved refractory to all previous therapeutic measures.

The seminal and tubal factors are the ones most frequently encountered. Thus, of the 374 couples with demonstrable abnormalities, tubal inadequacy or seminal inadequacy, or both, was met in 279 couples (74.6 per cent). This observation emphasizes the importance of a thorough examination of the semen and the tubal status. It goes without saying that in any precontraceptive fertility study of the married couple or the couple contemplating marriage, examination is necessarily limited to the jar specimen, since the Huhner test carries with it the possibility of conception. It should also be noted that a prognostic evaluation cannot be made of the specific fertility of any given specimen of semen. At the present time one can speak only of the morphologic characteristics, of estimated numbers of spermatozoa and of the degree and type of motility. Actual insemination repeated over a certain length of time is necessary in order to determine its compatibility and ultimate fertility.

In the group of 212 couples who did not use contraceptives, the incidence of pelvic abnormalities—59, or 27.8 per cent, endocrine dysfunction—23, or 10.8 per cent, seminal inadequacy—63, or 49.6 per cent, and tubal impairment—69, or 42.6 per cent, was essentially the same as in the contraceptive group (table 1 *A*, *B*, *C* and *D*, column 2). These factors were found 214 times in 172 couples, or 81.1 per cent (table 1*E*, column 2).

Because of limitation of space only a few examples of the factors discovered by the routine investigation are presented in the following reports of cases:

CASE 1.—*Observations.*—S. Z., a woman aged 30, had been married five years, had practiced contraception for four years and had involuntary sterility for one year. There had been hypomenorrhea ever since delayed menarche at the age of 17. The physical examination was essentially noncontributory. The basal metabolic rate was —20 per cent on one occasion and —15 per cent while the patient was receiving 2 grains (0.13 Gm.) of thyroid daily. Results of the Huhner test, examination of semen and uterotubal insufflation were normal.

Comment.—In this case hypomenorrhea long before marriage was an indication of lowered fertility, and hypothyroidism was

another factor which prevented conception; both were masked by the use of contraceptives.

CASE 2.—*Observations.*—E. H., a woman aged 29, had been married four years, had practiced contraception for two years and had involuntary sterility for two years. The menstrual history was normal except that during the past two years there had been occasional episodes of metrorrhagia. Kymographic uterotubal insufflation with auscultation determined nonpatency of the left tube and stricture of the right tube due to peritubal adhesions. The husband's semen was moderately oligospermic with reduced motility and vitality. Because of the recurrence of uterine bleeding, hysterography with Viscorayopaque [2] was done, and a uterine polyp was demonstrated.

Comment.—Important deterrents in this case were: nonpatency of left tube, stricture of the right tube, uterine polyp and oligospermia.

CASE 3.—*Observations.*—L. G., a woman aged 35, had been married eight years, had used contraceptive methods for three years and had involuntary sterility for five years. Menstruation was normal except for moderate dysmenorrhea. There was hypoplasia of the uterus and the cervix. The husband's semen was normal by the Huhner test. Uterotubal insufflation showed bilateral tubal nonpatency. Hysterosalpingography with Viscorayopaque confirmed the diagnosis of uterine hypoplasia and tubal nonpatency. The tubal closure was at the fimbriated ends.

Comment.—Bilateral tubal nonpatency and uterine hypoplasia. Pregnancy was prevented by the closed tubes, while another deterrent was the hypoplastic uterus. Contraception was therefore unnecessary and acted as a mask.

CASE 4.—*Observations.*—M. O., a woman aged 28, had been married four years, had practiced contraception for three years and had involuntary sterility for one year. The menstrual history was normal. Physical examination revealed a small, short hypoplastic cervix. There was bilateral tubal obstruction on two occasions. However, on the third attempt, tubal patency was established by the insufflation method. The patient became pregnant shortly afterward.

Comment.—This patient needed treatment to make her capable of becoming pregnant, and she was fortunate in conceiving. The factor of tubal obstruction made contraception unnecessary.

CASE 5.—*Observations.*—E. S., a woman aged 32, had been married nine years, had practiced contraception for eight years and had involuntary sterility for one year. The menses had been irregular since menarche at the age of 15½ and had decreased in duration and frequency until amenorrhea set in at the age of 21, continuing until the present. The uterus was small, the cervix was reduced to a little slender nipple-like structure, and the vaginal fornices were absent. The pubic hair was sparse. The skin of the face was wrinkled, and the patient appeared much older than her age. Uterotubal insufflation indicated tubal patency at an extremely low level of tonicity, and tubal contractions occurred infrequently. The husband's semen was normal. After several months' treatment with estrogen and progesterone, there was some increase in uterine size and some development of the endometrium as manifested by the appearance of staining. Stimulating roentgen therapy to the pituitary and the ovaries was recommended.

Comment.—This patient was not a good prospect for maternity and certainly one who did not necessarily need contraceptives. It would have been well to try earlier to restore her endocrine balance.

CASE 6.—*Observations.*—C. D., a woman aged 27, had been married five years, had practiced contraception for two years and had involuntary sterility for three years. The menstrual history and physical examination revealed essentially normal conditions except for stricture of the cervix. There was azoospermia by the Huhner test and by examination of the unmixed specimen. Uterotubal insufflation demonstrated bilateral tubal closure.

2. Viscorayopaque is a crystalloid iodine preparation (diethanolamine salt of 2,4-dioxo-3-iodo-6-methyl tetrahydropyridine acetic acid) made viscous by adding polyvinyl alcohol. It is prepared by Hoffman LaRoche, Nutley, N. J.

Comment.—It is impossible to say just how long this closure had been present, but obviously an earlier examination had been indicated, and contraceptive measures had been useless and needless.

CASE 7.—*Observations.*—E. J., a woman aged 28, had been married three and one-half years, had practiced contraception for two years and had involuntary sterility for one and one-half years. The menses were normal. Physical examination revealed a fibroid uterus in retroversion. The husband's semen was adequate in amount and in the number of spermatozoa. Uterotubal insufflation showed that the tubes, though patent, had atypical contractility. Shortly after insufflation the patient conceived.

Comment.—This patient came for consultation fairly soon after involuntary sterility was observed and was fortunate enough to conceive after treatment.

SECONDARY STERILITY

The smaller group of 289 cases of secondary sterility included 120 couples who had practiced contraception, 110 who had not and 59 concerning whom the contraceptive data were not noted. There were 22 women with premarital pregnancies (all terminating in induced abortion) and 38 women with multiple marriages (5 were married three times and 33 twice). Contraceptive data relating only to the present marriage were considered in this study.

In the group of 120 couples who had practiced contraception, abnormalities of the pelvic organs occurred in 21, or 17.5 per cent, endocrine dysfunction in 6, or 5 per cent, seminal inadequacy in 39, or 54.3 per cent, and tubal impairment in 40, or 47.1 per cent (table 1 *A*, *B*, *C* and *D*, column 3). These factors were found 106 times in 83 couples, or 69.2 per cent (table 1 *E*, column 3): Of these 83 couples with one or more demonstrable causes for sterility, tubal or seminal or both factors were present in 68, or 81.9 per cent. In secondary sterility, as in primary, the importance of the seminal and tubal status is immediately apparent.

In the group of 110 couples who had not used contraception, the incidence of demonstrable factors was approximately the same as in the contraceptive group: pelvic abnormalities in 28, or 25.5 per cent, endocrine dysfunction in 3, or 2.7 per cent, seminal inadequacy in 19, or 33.3 per cent, and tubal impairment in 40, or 49.4 per cent (table 1 *A*, *B*, *C* and *D*, column 4). These factors occurred 20 times in 77 couples, or 70 per cent (table 1 *E*, column 4).

Examples of the combination of sterility factors in relation to contraception as met in secondary sterility are presented in the following reports of cases:

CASE 1.—*Observations.*—C. S., a woman aged 26, had, years earlier, become pregnant and contracted gonorrhea as the result of rape. The pregnancy was terminated. A laparotomy was performed two years later, presumably because of adnexal infection. The right tube, part of the left tube and parts of both ovaries were resected. She subsequently married, at the age of 20. Contraception was practiced four years, after which a two year period of involuntary sterility ensued. Uterotubal insufflation demonstrated bilateral tubal nonpatency.

Comment.—The use of contraceptives in this case, in view of the previous history, was absurd.

CASE 2.—*Observations.*—S. P., a woman aged 31, who had been married nine years, had a full term normal delivery eight years ago. Contraceptive precautions were then taken for six years. After two years of involuntary sterility, medical advice was sought. Uterotubal insufflation showed that the tubes were patent. Physical examination was negative except for moderate retroversion of the uterus. The Huhner test demonstrated absence of spermatozoa in the vagina and cervix. Seminal responsibility was confirmed by demonstrating azoospermia in the jar specimen.

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Comment.—This case illustrates in clear relief what a boon early examination of both partners would have been. Also, it illustrates the necessity of not taking the fertility of the male for granted even after one child had been produced.

CASE 3.—*Observations.*—A. S., a woman aged 30, who had been married ten years, had a full term normal delivery seven years ago. A five year period of contraception was followed by involuntary sterility for two years. Menses had always been infrequent, occurring every two to eight months before marriage, every two to four months after marriage and every two months since the birth of the child. The basal metabolic rate had been — 40 per cent; and, following thyroid medication, it varied from — 10 per cent to — 20 per cent. Physical examination was essentially noncontributory. The Huhner test and examination of the unmixed specimen showed the semen to be normal. Uterotubal insufflation demonstrated tubal patency; however, the kymograph recorded atypical tubal contractions. Because of diminished pituitary-ovarian function, stimulating roentgen ray therapy to the pituitary and the ovaries was recommended.

Comment.—The lowered fertility of women with pronounced delays in the menstrual habit is well known. Contraceptives serve only to reduce it still further.

CASE 4.—*Observations.*—J. B., a woman aged 30, who had been married seven and one-half years, had a laparotomy one year after marriage for a left tubal pregnancy. Contraception for six years was followed by involuntary sterility of one year's duration. Physical examination was noncontributory except for sharp anteflexion of the uterus and nontender thickening of the left adnexal region. Uterotubal insufflation demonstrated bilateral tubal nonpatency on three occasions. At laparotomy, the right tube, which was completely obliterated, was resected, and the right ovary was transplanted into the uterine cornual opening. The left tube was obstructed about 1 inch (2.54 cm.) from its uterine end and was resected at this point.

Comment.—The needlessness of six years of contraception is obvious in this case, in view of the bilateral tubal blockage.

CASE 5.—*Observations.*—M. R., a woman aged 32, had been married ten years and had practiced contraception for six years. The patient became gravid two years ago but had a miscarriage at three months. Since then, conception has not recurred despite constant efforts in that direction. The menstrual history, physical examination and tubal status were normal. The Huhner test and repeated examinations of the jar specimens of semen showed decided oligospermia with greatly diminished motility and a high percentage of abnormal forms.

Comment.—This couple owed its infertility to seminal inadequacy, which would have responded to treatment, and valuable time was lost by the practice of contraception for six years.

COMMENT

The question that arises from the data herein presented is whether it should be considered necessary to determine the potential fertility of couples seeking contraceptive advice before such advice is proffered. Although physical examination does not reveal the factors responsible for sterility in every case, these factors are demonstrable in most instances. In this series, from one half to two thirds of the childless couples employing contraception were shown to have one or more causes for their infertility; many of these causes were clearly indicative.

The nature and severity of the causal factors show wide variation, and the degree of reduction in fertility corresponds to the possibility of applying therapeutic measures. Even without treatment, some women with reduced tubal patency and function due to peritubal adhesions become pregnant after a variable lapse of time; this applies to men who become fertile after having had oligospermia. On the other hand, despite the most painstaking and prolonged therapeutic measures, such conditions as tubal obstruction and azoospermia represent barriers to conception which may not be amenable even to surgical intervention.

Without doubt, however, the sooner the causal factor is determined and eliminated, the better the prognosis. In those couples in whom the factor is of an absolute nature and not susceptible to therapeutic relief—in short, the hopeless cases—it is better for the couple to know the facts as soon after marriage as possible. Unnecessary contraception may be immediately discontinued, stock may be taken of the situation, psychologic adjustments may be made and, if desired, steps may be taken for ultimate adoption of a child, or impregnation by a donor may be considered.

In most instances the loss of fertility is not absolute but relative. In such cases, early treatment is much more likely to achieve its end than that which delayed for several years in the mistaken belief that pregnancy will necessarily ensue within a short time after contraception is discontinued. If some couples do not elect to institute therapy immediately, they should at least be made aware of a possible lessening of fertility. Such awareness on the part of the general public might lead some couples to dispense with contraception from the beginning of their married lives until they prove whether or not the union is fertile. If they choose to elect parenthood thereafter they will not present the sad spectacle of frustrated childless matings.

TABLE 2.—*Contraceptive Methods Employed in Cases of Sterility*

Contraceptive Method	Primary, 466 Cases	Secondary, 129 Cases
Condom	174	31
Diaphragm	82	20
Condom-diaphragm	42	3
Withdrawal	11	6
Douche	7	4
Rhythm	5	..
Suppository	..	2
Jelly or cream	3	1
Not specified	142	63
Total	466	129

I am not unmindful of the possibility that some marriages would not be consummated if the partners were made cognizant by a premarital examination of their combined inability to have children, should they choose to know the facts before marriage. But this result may be offset in the long run by forestalling divorces, which eventually break up such unions after painful experiences and continual upheavals. On the other hand, the adoption of children presents a third alternative for those couples who are ideally mated otherwise and who would make good foster parents.

Not all newly married couples who employ contraception appear to seek medical advice concerning method and technic. In this series of 466 couples with primary sterility who used contraception, the most frequently used device was the condom (table 2). However, of 324 cases in which the methods were recorded, 129 (diaphragm 82, rhythm 5, condom-diaphragm 42), or practically 40 per cent, employed a device or method that necessitated medical instruction. When advice is sought the importance of determining potential fertility before instituting contraception can be suggested. When it is not sought, advantage may be taken at the time of medical consultation for other reasons to call attention to the desirability of determining potential fertility in instances in which married couples practice contraception of their own accord

A somewhat smaller percentage of couples with secondary sterility than of those with primary sterility employ contraception. Of those habituated to this practice, fewer consult physicians for contraceptive advice. In this series, 67 of 120 couples with secondary sterility who took artificial precautions since their last pregnancy gave reliable data. Of these, 23, or 34.3 per cent, consulted a physician in regard to the device to be employed (table 2).

The relatively infrequent resort to contraception in secondary sterility is probably due to the fact that, in most instances, previous gestations did not result in living children. In the 289 couples with secondary sterility there were 428 previous pregnancies (table 3), resulting in only 133 living children (31.1 per cent). Abortions, induced and spontaneous, totaled 247.

If a woman has given birth to one or more living children, the chances are greatly in favor of continued fertility, particularly if childbirth was uncomplicated. However, if there has been a nonviable issue, such as abortion and ectopic pregnancy, a prompt and thorough attempt should be made to determine the threshold of fertility of the couple in order to institute necessary corrective measures at the earliest possible moment. It may be proper in certain instances to stress the importance of such an investigation, even though the medical consultation has been sought for reasons other than sterility.

TABLE 3.—*Issue of Previous Pregnancies in 289 Cases of Secondary Sterility*

Full term living child	133	(31.1%)
Induced abortion	139	
Spontaneous abortion	108	
Ectopic	25	
Neonatal	15	
Stillbirth	8	
	428	

The sterilizing effect of induced abortions apparently has not been sufficiently appreciated. In a paper dealing with this question I have pointed out that tubal obstruction is more frequently encountered after induced abortions than after spontaneous miscarriages and other conditions.

Apart from the theoretic question of whether better babies are born of younger parents, they may be a safe investment against the uncertainties attendant on prolonged contraception. Whether or not couples wish to limit their families is not considered in this paper, for it is not the concern of the physician, however interested he may be in the religious, moral, economic or political aspect of this question. From the medical, pathologic and biologic point of view, however, it is important to call attention in general to the fact that many married couples lose precious time by contraverting Nature's purpose of propagating the race, thus forfeiting what is unquestionably the most precious possession in life, namely, the ability to create new life. For this reason persons contemplating marriage with the natural instinct of parenthood will do well to consult their physician as to whether they are potentially capable of having babies; or, in the event they do not choose the prophylactic examination, they will be wise to do so as soon after marriage as possible in order to discover the 15 per cent chance or more of sterile mating.

The premarital Wassermann examination was originally established to protect innocent persons from infection, but it has the further virtue of protecting the health of the unborn child. All agree concerning the validity of this procedure that is now legalized in many states. Without venturing into the controversial matter of premarital examination to determine the potential fertility of persons, it would, if they chose to take advantage of such an examination, have the virtue of preventing sterile matings in the first place and of pointing out what corrective measures may be necessary to enhance their prospects of having children. In all this discussion it must be constantly remembered that conception can occur only after a mating. In most instances a period of trial is necessary to determine the combined fertility of a married couple. Medically, one can determine only whether the mates have or have not obstacles to conception. It has been said that 85 per cent of all marriages, by and large, prove to be fruitful. This figure, however, may have been true for past generations. It is possible that sterility has increased in the last two or three decades.

CONCLUSION

1. A large number of sterile couples who practice contraception do so in the mistaken belief that they can conceive at will.

2. My records show that 70 per cent to 80 per cent of sterile couples present factors unfavorable to fertility.

3. The tubal factor was the most important deterrent to conception in from 47 per cent to 51 per cent of the sterile women employing contraceptives.

4. Seminal inadequacy was established in from 50 per cent to 54 per cent of those using contraceptives.

5. It is manifestly desirable for couples who wish to have children at some later date to be examined for potential fertility before they resort to the use of contraceptives. They may save themselves much needless trouble, and they will have a better chance of getting babies when they want them.

6. Contraceptives often act as a mask for concealed and unsuspected infertility of men and women. Recognition of this fact can lead to the early correction of factors that militate against fertility in those who desire children.

ABSTRACT OF DISCUSSION

DR. SHELDON PAYNE, Los Angeles: One is impressed by the fact that most couples seeking contraceptive advice plan to have children at some future time yet have never questioned their fertility. According to our most reliable statistics, probably at least 15 per cent of these couples will be unable to have children. Early diagnosis and a program planned for treatment, adoption of a child or whatever is indicated would seem a great asset. Persons contemplating marriage are coming to doctors in greater numbers than ever before. Most states require premarital blood tests of the prospective partners, and many insist on complete physical examinations. A large group of patients also seeks marital and contraceptive advice. With a few additions to the usual routine of questioning and examination, many cases of infertility can be determined. The diagnosis of male infertility is comparatively simple and often overlooked. Dr. Tyler and I reported a series of infertile couples observed by us during the past two years, selected because they had supposedly exhaustive studies elsewhere and adequate treatment without success. Sixty-seven per cent of these husbands were found below par by our standards; of these, 32 per cent responded sufficiently to treatment and their wives became pregnant. Now that more is known concerning factors in male infertility and better standards are applied, it is interesting to note the apparently increased incidence of male infertility—seminal inadequacy in from 50 to 54 per cent, in Dr. Rubin's report. Although ejaculated specimens from the normal male may vary considerably from day to day, if

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count, motility, viability, the percentage of abnormal forms and so on are considered, one usually finds such specimens adequate for determining which men will require further study. Most men will not object to such an examination, which may be incorporated in the premarital examination. Those proved inadequate are usually most anxious for further investigation. Early evaluation of infertility in women, with their more complicated and hidden mechanisms, is more difficult. Much can be gained by history and physical examination. However, it is often difficult to obtain cooperation much further unless the woman has some menstrual disturbance or is confronted with undesired infertility. With all our testing of both men and women, we can only express an opinion regarding their relative fertility. The real test comes with unobstructed mating and time.

DR. PENDLETON TOMPKINS, San Francisco: Dr. Rubin has raised the question whether we are giving contraceptive advice to persons who are already predestined to be infertile. Dr. Payne has just said that about 15 per cent of couples are infertile. It therefore follows that if contraceptive advice is given to 100 newly married couples, in 15 instances such advice is unnecessary. The problem, then, is to determine which of these 100 couples do not require the advice. Sterility studies indicate that men are responsible for infertility in about 40 per cent of the cases. Translating that figure to these 15 infertile couples, we find fault in the man in about 6 cases. Some of these faults, such as hypospadias, might have been discovered beforehand by anatomic examination. Suspicion of endocrine abnormality is often aroused by a simple physical examination and, if necessary, can be proved by laboratory tests. When one is dealing with newly married couples, the history is apt to be more reliable than at any other time in the lives of those couples. A history of gonorrhea or of trauma, either surgical or accidental, is important, and particularly a history of the prospective father's occupation. Many occupations heretofore not recognized as influencing fertility have an important significance. X-ray workers, workers with high frequency currents, men who drive taxicabs or trucks, men who sit for long hours in one position and pilots of planes are among the group whose occupation is suspected. By history and physical examination, 4 or 6 of the 100 prospective fathers might be infertile and might require further study. In the wives, the history of gonorrhea or appendectomy, particularly if hospitalization was prolonged or if drains were inserted, is likewise important. Tuberculosis is important because it may lead to tubal closure. So are previous pregnancies, whether ending in abortion, miscarriage or otherwise. Dr. Rubin did not imply that contraceptive practices decreased fertility. Nevertheless, there are dangerous contraceptive devices which are still in use and which ought to be ostracized and rendered illegal. I refer to all contraceptive devices which are inserted into the cervical canal or into the uterus. These are dangerous and should never be employed in medical practice today.

DR. ERIC M. MATSNER, New York: It is important to break down further the types of contraceptives that were used by the group; also to know whether, and in what percentage of cases, the contraceptives utilized were prescribed by a physician after a thorough pelvic examination. The point I want to stress is the implication that the use of contraceptives in a certain percentage of these cases led to future infertility or sterility. I think it is important to determine what percentage of those cases can be attributed to the use of contraceptives. It has been my experience that the premarital or early marital examination is an ideal opportunity to discover any of the stigmas which Dr. Rubin has mentioned. For this reason, I consider it desirable that all premarital or early marital examinations include a thorough pelvic examination. I should like to ask Dr. Rubin what he would advise in this respect and also the technics he advocates as a means of child-spacing after the delivery of one or more children.

DR. I. C. RUBIN, New York: I am not an expert on child-spacing. I don't know much about it. As a matter of fact, I have not advised contraception to the extent he has. I work on the opposite pole. I am interested in raising fertility and in lessening sterility. I am not interested in what type of contraception is used. I pointed out that various types have been used. What they are, whether they are ineffective or even dangerous is not the point. When they are dangerous, they of course reduce fertility by their own effect, but I was speaking particularly of the general masking of infertility by the use of contraception, which wastes valuable time and deludes couples into a false sense of security, from which they awaken one day with a jolt and with great chagrin. I have seen few women who can conceive at will following the use of contraception. They are the exceptions.

THE PROBLEM OF PEPTIC ULCER

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For humanitarian and economic reasons the problem of peptic ulcer [1] has been and is a great challenge to medical science.

The problem of peptic ulcer challenges medical science today because, among the chronic diseases, it ranks tenth as a cause of death and twelfth as a cause of days lost from work.[14] Among a group of employees of the Metropolitan Life Insurance Co., consisting of approximately an equal number of men (2,125) and women (2,155) above the age of 30 years, the incidence of proved cases was 2.4 per cent during a period of 10 years.[15] If this incidence prevails in the nation's population, there are approximately 1.5 million people in the United States above the age of 30 in whom peptic ulcers develop during a period of 10 years. It has been estimated from evidence obtained at necropsy that from 5 to 12 per cent of the population become afflicted with peptic ulcer during a modern lifetime. Not all may consult a physician, however, because of the mild character of their symptoms.

NATURAL HISTORY

Certain points regarding the natural history of peptic ulcer command serious consideration in relation to the cause and prevention of the disease.

The Changed Incidence of Peptic Ulcer According to Necropsy Records.—One of the mysteries of the natural history of peptic ulcer is the rarity with which pathologists reported the occurrence of duodenal ulcer during the nineteenth century. For example, Brinton in 1856 reviewed 7,226 necropsy reports and concluded that gastric ulcer occurred in approximately 5 per cent of all persons and omitted any statistics on duodenal ulcer.[16] Perry and Shaw [17] in 1893 reviewed 17,652 necropsy records from 1826 to 1892 and recorded an incidence of 0.4 per cent (the total of all types of duodenal ulcer was 0.8 per cent; 149 cases) for duodenal ulcer. At the turn of this century it was commonly taught that the necropsy ratio of gastric to duodenal ulcer was as high

From the Department of Physiology, Northwestern University Medical School.

Read in the General Scientific Meetings at the Ninety-Fifth Annual Session of the American Medical Association, San Francisco, July 2, 1946.

Because of lack of space, this article is abbreviated in THE JOURNAL by omission of the historical portion of the text and footnotes 1a to 13 inclusive. The complete article will appear in the author's reprints.

1. The expression "peptic ulcer" is used in a generic sense in this paper and refers to any benign and nonspecific ulcer that is located in those portions of the alimentary tract which happen to be bathed with gastric juice.

14. National Health Survey, Sickness and Medical Care Series, National Institute of Health, Bulletin 6, United States Public Health Service, Washington, D. C., 1938 (1939 revision).

15. Jennison, J.: Am. J. M. Sc. **196**: 654, 1938.

16. Brinton, W.: On the Pathology, Symptoms and Treatment of Ulcer of the Stomach, London, J. Churchill, 1857; Diseases of the Stomach, ibid., 1859.

17. Perry, E. A., and Shaw, L. E.: Guy's Hosp. Rep. **50**: 171, 1893.

as 20:1 (Hurst[18] and Hauser[19]). But even before the turn of this century, necropsy reports from Germany indicated that the incidence of duodenal ulcer was increasing. In 1914 to 1921 two German reports on 3,058 necropsies recorded an incidence of 6.9 per cent for acute and chronic gastric ulcer and 5.3 per cent for acute and chronic duodenal ulcer.[20] In England in 1929 Hurst and Stewart[18] found at necropsy an incidence of 4.33 per cent for chronic gastric ulcer or scars and 5.75 per cent for chronic duodenal ulcer or scars. The same change has occurred in the United States. In Philadelphia the incidence of duodenal ulcer at necropsy increased during the period of 1920 to 1937.[21] As late as 1936 and 1937 necropsy records in Philadelphia and Chicago showed that, though acute and chronic ulcers predominated in the stomach, chronic ulcers were equally distributed between the stomach and the duodenum[22] (table 1).

Thus, at the present time necropsy records in the United States and England indicate that chronic gastric and duodenal ulcers occur with the same frequency. If one accepts Brinton's figure of a 5 per cent necropsy incidence of peptic ulcer in 1850 and the Chicago figure of 5.2 per cent (among white persons) for the 1929 to 1936 period, then an increase in the incidence of peptic ulcer has not occurred during the last hundred years in northern Europe and the United States. It would then appear that during the past hundred years the location of about half the peptic ulcers which occur has shifted from the stomach to the duodenum.

Another mystery in the natural history of peptic ulcer, according to the necropsy records, is the apparent reversal of the sex ratio of the incidence of the disease. During the middle of the last century, when gastric ulcer apparently predominated, the disease developed chiefly in women. Today, when the necropsy incidence of chronic peptic ulcer is about equally divided between

TABLE 1.—*Incidence of Peptic Ulcer in Autopsies According to Sex and Location*

Sex	No. Autopsies per Yr.	No. Ulcers per Yr.	%	Site	Total Ulcers	Ulcers per Yr.	Comment
Philadelphia General Hospital: Autopsies, 22,956 * 13 Years: 1920-1932							
Male	591	11.7	2.00	Stom.	148	11.4	32% chronic
Female	446	6.6	1.48	Duod.	89	6.0	21% chronic
5 Years: 1933-1937							
Male	1,081	44.2	4.10	Stom.	178	35.6	38% chronic
Female	815	18.2	2.20	Duod.	134	26.8	31% chronic
Chicago Cook County Hospital: Autopsies, 9,171 † 8 Years: 1929-1936 (Ulcers and Scars)							
Male	677	39.6	5.85	Stom.	230	29.0	29% chronic
Female	470	13.7	2.92	Duod.	197	25.0	42% chronic

* Fifty-seven per cent males and † 59 per cent males by communication from the respective departments of pathology.

the stomach and the duodenum, peptic ulcer occurs chiefly in men in both locations (table 1).

Changing Incidence as Indicated by Mortality Records.—Many of the necropsy reports are subject to various criticisms. However, the shifts they manifest in the location and sex ratio is supported by the mortality statistics.

Since 1900 in the United States the death rate per 100,000 from peptic ulcer has increased from 2.7 to 6.8 in 1943.[23] An approximate plateau was reached

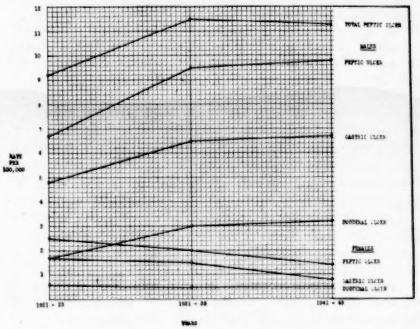

Chart 1.—Trend of mortality rate from peptic ulcer, Metropolitan Life Insurance Company.

in 1935. It is remarkable that since 1920 the death rate in men for both gastric and duodenal ulcer has increased, whereas that for women has decreased[24] (chart 1). This fact is remarkable because it shows that the death rate from peptic ulcer since 1920 cannot be ascribed justifiably to the increased recognition of the disease, which is particularly true of duodenal ulcer. Peptic ulcer is certainly as easily diagnosed in women as in men. Further, this change occurred during a period in which deaths from cancer of the stomach increased in both sexes.[24a]

Change in Incidence Based on Clinical Experience.—The apparent increase in the incidence of duodenal ulcer and the shift in the sex ratio of peptic ulcer also conforms with clinical experience. In the early years of this century Moynihan and W. J. and C. H. Mayo, as is well known, reported a greater clinical incidence of duodenal than of gastric ulcer. Later Jennison[15] in a group of employees of the Metropolitan Life Insurance Co. observed a duodenal to gastric ulcer ratio of 13.6:1. Emery and Monroe[25] reported a duodenal to gastric ulcer ratio of 5.6:1 and a male to female ratio of 5.5:1. Balfour and Eusterman[26] found a duodenal to gastric ulcer ratio of 12:1 and a male to female ratio of 4:1.

The ratios in table 2 show that the clinical observations on the location and the sex distribution of peptic ulcer check well with the mortality statistics, except in one regard, namely, that more people die from gastric than from duodenal ulcer. This exception shows only that, as a rule, gastric perforation and hemorrhage is more lethal than duodenal, since the clinical reports indicate that 4 duodenal perforations occur for 1 gastric

18. Hurst, A. F., and Stewart, M. J.: Gastric and Duodenal Ulcer, New York, Oxford University Press, 1929.
19. Hauser, G., in Henke, F., and Lubarsch, O.: Handbuch der speziellen pathologischen Anatomie und Histologie, Berlin, Julius Springer, 1926, vol. 4, pt. 1.
20. Hart, C.: Mitt. a. d. Grenzgeb. d. Med. u. Chir. **31**: 350, 1919. Holzweissig, M.: ibid. **35**: 16, 1922.
21. Gordon, J. S., and Manning, J. J.: Am. J. M. Sc. **202**: 423, 1941.
22. Portis, S. A., and Jaffe, R. H.: A Study of Peptic Ulcer Based on Necropsy Records, J. A. M. A. **110**: 6 (Jan. 1) 1938. Gordon.[21]
23. Vital Statistics, Special Reports, United States Department of Commerce and Labor, Bureau of the Census, Sept. 10, 1942, vol. 16, no. 31, p. 125.
24. (*a*) United States Department of Commerce and Labor, Bureau of the Census, Mortality Statistics, 1920-1945. (*b*) Sex Differences in Mortality Trends, Statist. Bull., Metrop. Life Insur. Co. (no. 9) **26**: 5, 1945.
25. Emery, E. S., Jr., and Monroe, R. T.: Peptic Ulcer: Nature and Treatment Based on Study of 1,435 Cases, Arch. Int. Med. **55**: 271 (Feb.) 1935.
26. Eusterman, G. B., and Balfour, D. C.: The Stomach and Duodenum, Philadelphia, W. B. Saunders Company, 1936.

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perforation and that little difference exists between duodenal and gastric ulcers in their tendency to bleed.[27]

Comment: The cause of the shift in the location and sex ratio of peptic ulcer is not subject to explanation at this time. Medical history records that diseases have been overlooked or underestimated until they were publicized. However, duodenal ulcer was well publicized by 1920, and some important etiologic factor must have been concerned in the increased incidence of this form of the disease in men since 1920 in contrast to the absence of an increase in women.

Age and Peptic Ulcer.—Another fact in the natural history of peptic ulcer must be considered as being related to the question of the cause of gastric ulcer, namely, the relation of age to the incidence of the disease.

Ninety per cent of the cases of peptic ulcer are first diagnosed after the age of 20. This may be considered an argument against certain types of infection being concerned, since children and adolescents are as prone to infectious diseases as adults. Foci of infection may be more common in the adult, but the evidence is inadequate. Children and adolescents are, however, relatively free from vascular disease. A point of interest in relation to the acid theory of the genesis of ulcer is that the gastric secretory response to a test meal does not reach maturity until the age of 18 in men and 20 in women.[28] The factor of "sustained anxiety," or responsibility, is more prevalent after the age of 20. The possibility of a combination of these factors must be considered, including some subtle effect of the sex hormones.[29]

Seasonal Variation in the Incidence of Peptic Ulcer.—There is a general impression that peptic ulcer tends to occur or recur during the autumn and spring months. This was emphasized by Hütter.[30] Little by way of satisfactory clinical data has been offered in support of this impression. However, the impression is confirmed by the mortality data of the United States Bureau of Census [24a] for each month of the year for a five year period, presented as a graph in chart 2. It is of interest to note that the curve of mortality graphed by months, except for the month of February, conforms with that of vascular disease, nephritis and pneumonia.

Comment: The seasonal variation in the incidence of peptic ulcer must have some etiologic significance. It has been explained as being due to the incidence of upper respiratory infections. If this is a factor it cannot be the only one responsible, since many more persons have respiratory infections than peptic ulcer. There is a lack of good evidence to show that gastric secretion is less during the summer months. However, I know from an extensive experience that hot weather decreases the gastric secretory response of dogs to a test meal. It may be due to summer vacations or to a decrease in the drive to accomplish, which is believed to be incident to the late spring and summer months. Some subtle metabolic derangement has been suspected but not named.[25] Riggs, Boles, Reinhold and Shore [31] found a decrease in blood pressure, pulse rate, hemoglobin, hematocrit and serum proteins during the summer months in 40 subjects who were studied for one year. A similar study of gastric secretion would yield valuable information.

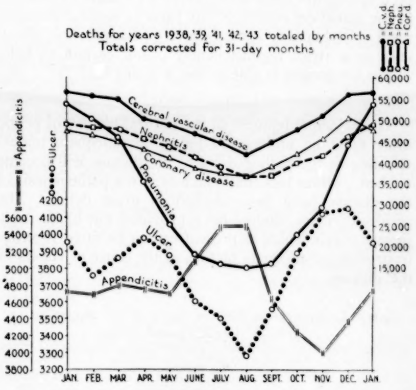

Chart 2.—Deaths in the United States of America from various diseases, grouped by months.

TABLE 2.—*Clinical Observations on the Location and Sex Distribution of Peptic Ulcer Compared with Mortality Statistics*

Source of Data	Duodenal-Gastric Ulcer Ratio	Chronic Peptic Ulcers Male-Female Ratio
Clinical	**D. U. : G. U.**	**M. : F.**
Jennison	13.6 : 1	4.5 : 1
Emery and Monroe	5.6 : 1	5.5 : 1
Balfour and Eusterman	12.0 : 1	4.0 : 1
Mortality	**D. U. : G. U.**	**M. : F.**
U. S. Bur. Census 1937-1938.	1 : 2.9	3 : 1
Males	1 : 2.7	
Females	1 : 3.6	

Source	Sex Ratio of Gastric Ulcer	Sex Ratio of Duodenal Ulcer
Clinical	**M. : F.**	**M. : F.**
Balfour and Eusterman	3.9 : 1	4.0 : 1
Mortality		
U. S. Bur. Census 1937-1938.	2.9 : 1	3.6 : 1

Recurrences.—The most discouraging characteristic of peptic ulcer is its likelihood to recur. This was known to the early students of the disease [32] who warned against the conclusion that immediate good results indicate a permanent "cure." Greenough and Joslin as early as 1899 reported a recurrence in 47 per cent of patients who had apparently been cured. The recurrence rate reported in the most recent articles which present data are shown in table 3.

Emery and Monroe [18] have presented data regarding the factors which appeared to be concerned in causing a recurrence. They found that "often no cause is assignable." In 1,279 patients studied in this regard, the recurrences seemed to be due to fatigue in 334, emotional excitement in 258 and infections (upper respiratory) in 167 patients. In the remaining 40 per cent no exciting factor appeared to be concerned. More data of this type are needed. Most of the data on

27. Bockus, H. L.: Gastroenterology, Philadelphia, W. B. Saunders Company, 1943, vol. 1. Eusterman and Balfour.[26]
28. Vanzant, F. R.; Alvarez, W. C.; Eusterman, G. B.; Dunn, H. L., and Berkson, J.: Normal Range of Gastric Acidity from Youth to Old Age, Arch. Int. Med. **49**: 345 (March) 1932. Sagal, Z.; Marks, J. A., and Kantor, J. L.: Ann. Int. Med. **7**: 76, 1933.
29. Sandweiss, D. J.; Saltzstein, H. C., and Farbman, A.: Am. J. Digest. Dis. **5**: 24, 1938. Culmer, C. U.; Atkinson, A. J., and Ivy, A. C.: Endocrinology **24**: 631, 1939.
30. Hütter, K.: Arch. f. klin. Chir. **151**: 651, 1928.
31. Riggs, H. E.; Boles, R. S.; Reinhold, J. G., and Shore, P. S.: Gastroenterology **3**: 480, 1944.
32. Abercrombie.[9] Cruveilhier.[4] Lebert.[7] Brinton.[16]

emotional factors submitted recently have come from a consideration of the personality characteristics of the patient with ulcer than from the extent to which an emotional disturbance is the cause of the recurrence.

In regard to recurrences, it seems certain that the willingness of the patient to cooperate by continuing on a therapeutic regimen is a difficult feature to evaluate in the statistical results of any form of medical management. Perhaps, as some believe (Alvarez), the adherence to a strict regimen solely is not certain to help, unless the patient is able to live a "calm life." [33]

PATHOGENESIS

The principal features of the natural history of peptic ulcer must be understood before an adequate understanding of the pathogenesis of the disease will become evident. Other less subtle factors in the pathogenesis of the disease have been studied in great detail. The results of these studies have provided the blocks of a jigsaw puzzle which at present cannot be fitted together to provide an adequate picture of the cause or causes of the disease.

TABLE 3.—*Recurrence Rate in Peptic Ulcer According to Articles Which Present Data*

Observer	No. Cases	No. Recurrences at 1 Yr., %	No. Recurrences at 2 Yrs. %	Comment
Nielsen	151	71	87	After care not given
Emery and Monroe	1,085	79*	84*	After care variable
St. John and Flood	140	..	65	6 feedings a day and alkalis as necessary
Raimondi and Collen	151	66	..	6 feedings and Al gel
Emery and Monroe	58	..	75*	"Strict Sippy" 9-12 mo.
	908	..	87*	"Lax Sippy"; 5 meals and alkaline powders

* A period of several years; the percentages refer to those patients who are "free of symptoms," and the cases are not referred to by the authors as "recurrences."

Numerous theories have been proposed regarding the cause of the acute ulcer which develops into a "chronic ulcer." These will be listed but not discussed. The best known theories are: (*a*) the acid-peptic; (*b*) the vascular: infarction, spasm, tugging on the vessels; (*c*) the gastritic: specific streptococcus, nonspecific inflammation from acid or rough and irritating foods; (*d*) the neurogenic: vascular spasm, hypermotility and secretion; (*e*) the allergic; (*f*) the nutritional; (*g*) the unknown constitutional, and (*h*) the unknown metabolic or endocrine. Several factors which predispose to chronicity have been established. They are: (*a*) acid; (*b*) rough food; (*c*) gastric retention; (*d*) poor nutrition, and (*e*) mucosal gradient of susceptibility to acid, the rank order of decreased susceptibility being the fundic, the lesser curvature in the pyloric region, the pyloric, duodenal, jejunal and ileal mucosa. The complexity of the problem and the discrepancies in the clinical and experimental literature are stumbling blocks to the clear and scientific understanding of the problem of the etiology of this disease.

Analytically it is clear that the ulcer can be due to (*a*) abnormal external destructive factors acting on the mucosa, or (*b*) decrease in the normal resistance of the mucosa to injury and in its normal healing properties or (*c*) to a combination of both.

33. The Need for Good Data on the Incidence of Recurrences of Peptic Ulcer, editorial, Gastroenterology **6**: 216, 1946.

It is also clear that a chronic peptic ulcer starts as an acute ulcer; in fact, there is no other tenable assumption. Whether there is some type of acute ulcer or an acute ulcer produced by some specific cause which gives rise to a chronic ulcer is unknown. I suspect that an acute ulcer produced by any means in the right place at the right time in a patient with ulcer will become chronic.

At present one can state with confidence that there is only one type of ulcer which occurs in man the counterpart of which has been produced experimentally. This is the postoperative gastrojejunal ulcer. It has been clearly demonstrated by Mann and his associates and by workers in this laboratory that this type of ulcer is due primarily to acid acting on the jejunal mucosa which is more susceptible to acid than the gastric and duodenal mucosa.[34] The factors of motor drive and inadequate nutrition are secondary factors which operate to increase the rate of development of the ulcer.

However, ulcers have been produced in the stomach and duodenum of the cat and dog by the continuous administration of histamine. These ulcers morphologically resemble the acute perforating type of ulcer in man.[35] It has been concluded that the "histamine ulcer" is due to the continuous secretion of acid; however, this has not been established as the sole factor because doses of histamine have been used which may exert a local angiotoxic effect on the mucosa. The same holds for the ulcers produced with caffeine.[36] In the rabbit a gastric ulcer which morphologically resembles chronic gastric ulcer in man has been produced. Ulcers occur spontaneously after bilateral vagotomy, if a rough diet is fed, or after an acute ulcer is produced by excision, if a rough diet is fed.[37]

Differentiation of an Acute Ulcer From a "Chronic" Peptic Ulcer in Regard to Healing.—One of the well established facts regarding ulcer was discovered in 1863 by Pavy, namely, that acute ulcers produced in animals heal rapidly or in three or four weeks.[38] The same is true of acute ulcers of the stomach in non-ulcer-susceptible human subjects.[39]

Recently Cummins, Grossman and Ivy [40] have presented evidence on the "healing time" of 63 duodenal and 6 gastric ulcers on rest and a rather strict Sippy regimen. Excluding 1 case which required two hundred and thirty days, the healing time ranged from thirteen to sixty-eight days, the average time being approximately forty days. These data support the commonly expressed statement that "chronic" duodenal or gastric ulcer in man usually heals rapidly under conditions of strict medical management. This emphasizes an important but simple principle in regard to the etiology of "chronic" peptic ulcer: the difference between the healing of an acute ulcer produced by excision and that of a "chronic" peptic ulcer is that in most ulcer patients "favorable conditions" are required for prompt healing.

34. Bachrach, W. H.; Grossman, M. I., and Ivy, A. C.: Gastroenterology **6**: 563, 1946.
35. Hay, L. J.; Vorco, R. L.; Code, C. F., and Wangensteen, O. H.: Surg., Gynec. & Obst. **75**: 170, 1942.
36. Roth, J. A.; Ivy, A. C., and Atkinson, A. J.: Caffeine and "Peptic" Ulcer, J. A. M. A. **126**: 814 (Nov. 25) 1944. Roth, J. A., and Ivy, A. C.: Surgery **17**: 644, 1945.
37. Beazell, J. M., and Ivy, A. C.: Chronic Gastric Ulcer Following Bilateral Vagotomy in the Rabbit and Dog, Arch. Path. **22**: 213 (Aug.) 1936.
38. Pavy, F. W.: Phil. Tr., London **153**: 161, 1863.
39. Riegel, F.: Diseases of the Stomach, Philadelphia, W. B. Saunders Company, 1905, p. 564. Wolf, S., and Wolff, H. G.: Human Gastric Function, New York, Oxford University Press, 1943.
40. Cummins, G. M.; Grossman, M. I., and Ivy, A. C.: Gastroenterology **7**: 20, 1946.

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AN ANALYSIS OF THE PSYCHOSOMATIC ASPECT OF THE ETIOLOGY OF PEPTIC ULCER

Long before the evolution of the modern school of psychoanalysis and psychosomatic medicine, discerning physicians recognized that emotional states played an important role in certain diseases. In this connection, peptic ulcer has been considered to be a "disease of civilization." However, one should not be too hasty in accepting a causal relationship between social stress and peptic ulcer. One should remember that the Abyssinians and the Hindus of southern India have a high incidence of gastric ulcer. Also, whether the increase of the incidence of a disease is real or apparent is a ubiquitous and frequently a difficult problem in medical practice.

It is important to decide whether psychic factors are merely contributory or causative in peptic ulcer. Does psychic trauma affect adversely an existing ulcer, as is generally conceded for some patients, or is it a causative factor? For example, it is known that physical and mental rest is important in determining the course of tuberculosis, but certainly a psychoanalyst would not deny to the Mycobacterium tuberculosis the role of the primary etiologic agent. The consideration of the patient as a whole should give proper but not undue emphasis to the psychic aspects of a disease.

In reading the psychosomatic literature, I have been impressed with the rather wide range of personality types which have been described as "typical" of the patient with peptic ulcer, as well as with the absence of a control group. The same personality types are described for "spastic colon," for mucous colitis, for ulcerative colitis and for biliary dyskinesia. If one omits the difficulty of satisfactorily explaining such observations, the next link in the chain of circumstances that may be concerned is: do emotional states evince typical physiologic responses in the stomach?

It is well known that displeasurable or dysphoric states inhibit gastric secretion and motility and that pleasurable or euphoric states increase secretion.[41] Since 1920,[42] reports have appeared indicating that hypersecretion and motility of the stomach may be caused in some persons by dysphoric states, such as anxiety, stress, guilt, frustration, hostility and resentment.[43] These studies, though exceedingly important, leave much to be desired from the quantitative point of view of a person who is familiar with the normal variations in gastric secretion and motility.

However, for hypothetic purposes let it be assumed (1) that the patient with peptic ulcer has a characteristic personality pattern and (2) that certain emotional states regularly induce gastric hyperactivity. The next question in the chain of circumstances is: can a state of gastric hyperactivity alone lead to a peptic ulcer?

The literature on this question is extensive, and my associates and I have extensively contributed to it. The evidence presumptively supports the view that hyperactivity of the stomach may cause gastric or duodenal ulcer. However, a definitive conclusion is unwarranted because there are important gaps in the evidence. Thus, the three propositions which support the view that dysphoric states, even in constitutionally predisposed persons, cause peptic ulcer are still unproved.

The physiologic anatomy on which the concept of "psychogenic stimulation" of gastric secretion is based warrants consideration. It has been established that the vagus nerves are entirely responsible for the cephalic phase of gastric secretion. It has also been established that the vagi are essential for what is termed "gastric motility on tone." For these reasons it has been tacitly assumed that the stimulation of gastric activity by emotional states also utilizes the vagal pathway. This assumption, though plausible and reasonable, awaits proof. Should it be established that the vagi are concerned, it is believed that the stimulation of secretion and motility should not be confused with that which is dependent on the taking and thought of food. To avoid such confusion, it has been suggested that the expression "emotogenic secretion" be used to designate gastric secretion which occurs as a result of certain affective states directly unrelated to the taking or thought of food.[44] The same adjective would be used to qualify changes in motility.

TREATMENT

The therapy of peptic ulcer presents two problems. One is to promote the rapidest possible healing of the active ulcer and, if present, to take care of the complication of obstruction, hemorrhage or perforation. The second, and at present the most difficult, is to prevent recurrences.

The Active Ulcer.—Medical: The principles of the treatment of the active uncomplicated gastric or duodenal ulcer, I believe, are highly satisfactory and well established: (*a*) physical and emotional rest, sedatives as indicated, and reassurance; (*b*) the buffering of acid with frequent small feedings, a highly nutritious diet to promote healing and taking advantage of the inhibitory action of fat on the gastric secretions; (*c*) antacid medicaments for the control of acidity, avoiding alteration of body chemistry as much as possible; (*d*) antispasmodics, as indicated and as tolerated by the patient; (*e*) continuous drip or therapeutic aspiration as indicated in special cases, and (*f*) the removal of foci of infection.

The Prevention of Recurrences.—Surgical: At present subtotal gastric resection appears to be the method of choice among most surgeons for the prevention of recurrences of peptic ulcer. I have reviewed nine articles published since 1941 on the extent of the failure of the operation. The mortality is low, not higher than 4 per cent in the hands of skilful surgeons. The operation failed to give partial or complete relief in only 12 per cent of 1,472 patients reported on [45]; however, in one paper (Jordan) only 43 per cent were completely free of symptoms. Kiefer [45b] writes that "the incidence of jejunal ulcer following subtotal gastrectomy for peptic ulcer is not accurately known." Experimentally Dr. Fauley and I [46] found that if the major portion of the acid-secreting mucosa is excised (fundusectomy) as suggested by Connell,[47] jejunal ulcer does not develop in the Mann-Williamson dog. (The Mann-Williamson dog has a gastrojejunostomy and drainage of the bile

41. Ivy, A. C.: Am. J. Digest. Dis. & Nutrition **1**: 845, 1935.
42. Miller, R. J.; Bergeim, O.; Rehfuss, M. E., and Hawk, P. B.: Am. J. Physiol. **52**: 1, 1920. Miller, R. J.; Bergeim, O., and Hawk, P. B.: Science **52**: 253, 1920.
43. Mittlemann, B., and Wolff, H. G.: Psychosom. Med. **4**: 5, 1942.

44. Grossman, M. I.; Bachrach, W. H., and Ivy, A. C.: A Physiological Analysis of the Problem of the Psychosomatic Etiology of Peptic Ulcer, to be published.
45. (*a*) Mage, S.: Ann. Surg. **116**: 729, 1942. Allen, A. W., and Welch, C. E.: ibid. **115**: 530, 1942. Custer, M. D.; Butt, H. R., and Waugh, J. M., cited by Berkman, J. M., and Heck, F. J.: Symptoms Following Partial Gastric Resection, Gastroenterology **5**: 85 (Aug.) 1945. Hinton, J.: Ann. Surg. **117**: 498, 1943. (*b*) Kiefer, E. D.: Jejunal Ulcers and Recurrent Hemorrhages After Partial and Subtotal Gastrectomy for Peptic Ulcer, J. A. M. A. **120**: 819 (Nov. 14) 1942. (*c*) Mateer, J. G., in discussion on Jordan, S. M.: End Results of Radical Surgery of the Gastrointestinal Tract as Seen by a Gastroenterologist, ibid. **116**: 586 (Feb. 15) 1941. Miller, C. G.: Surgery **12**: 383, 1942. Jordan, S. M.: End Results of Radical Surgery of the Gastrointestinal Tract as Seen by a Gastroenterologist, J. A. M. A. **116**: 586 (Feb. 15) 1941. Ingelfinger, E. J.: New England J. Med. **231**: 321, 1944. Reinhoff, W. F.: Ann. Surg. **121**: 583, 1945.
46. Fauley, G. B., and Ivy, A. C.: Surg., Gynec. & Obst. **63**: 717, 1936.
47. Connell, F. G.: Surg., Gynec. & Obst. **53**: 750, 1931.

and pancreatic juice into the last 15 cm. of the ileum.) This experimentally demonstrates the importance of removing as much acid-secreting mucosa as is practically feasible, if jejunal ulcers are to be prevented. However, the smaller the gastric remnant the more likely are postprandial symptoms to occur.

The preliminary reports on the supradiaphragmatic vagotomy are encouraging.[48] It is too early to evaluate the effect of the operation on the prevention of recurrences. It is an operation which should be given a clinical trial. It will certainly abolish the cephalic phase of gastric secretion, and it may sever the nervous pathway involved in the production of the psychosomatic abnormalities hypothetically involved in the production of gastric or duodenal ulcer. The procedure has the disadvantage of predisposing to gastric atony and retention, as well as to achalasia of the cardiac sphincter. It leaves the inhibitory motor and vasoconstrictor action of the sympathetic innervation unopposed. If the human stomach resembles that of the rabbit, gastric ulcers may occur if rough food is eaten. It will not prevent alcoholic beverages from producing gastric secretion, since alcohol probably acts by exciting histamine formation. It should not alter the effect which smoking produces on the stomach.[49]

Every one will grant that destructive surgery is not the ideal approach to the solution of the problem of the prevention of recurrences.

The "Ideal Approach" to the Prevention of Recurrences.—As a working hypothesis, I have made several assumptions in regard to the medical or the pharmaceutic approach to the solution of the problem of the prevention of recurrences. One is that most patients with ulcer will not learn to live a "calm life" and remain on a strict management regimen. Another is that they will take a medicament on arising or before retiring. Hypothetically, if it were possible (*a*) to increase the resistance of the gastric and duodenal mucosa to injury or (*b*) to increase its healing potential, the recurrence of ulcer would be prevented. Or, on the basis of the important role that acid plays in injuring the mucosa and fibroblasts, it may be assumed that if a substance were available which abolished the formation of acid without having side reactions it would reduce the recurrence of ulcers.

Dr. Garrido in this laboratory has been making a systematic study of the synthetic antihistamine and atropine-like compounds. To date a satisfactory chemical has not been found. However, since the mechanism for the formation of hydrochloric acid by the parietal cell is so specific for the parietal cell, some substance which blocks the mechanism should be found in the course of time. Enterogastrone may be such a substance.

Enterogastrone is an autacoid or substance which is produced by the intestinal mucosa in the presence of adequate concentrations of fat and sugar in the chyme and which inhibits gastric secretion and motility. This substance given parenterally inhibits or abolishes the gastric secretory response to histamine.

Over five years ago my associates and I (Drs. Greengard, Fauley and Atkinson) started to administer parenterally an intestinal extract containing enterogastrone to Mann-Williamson dogs. Postoperative jejunal ulcer develops in 98 per cent of Mann-Williamson dogs if they are not treated. When 33 were treated daily parenterally for one year jejunal ulcer developed in only 21 per cent. When the treatment was stopped, it was expected that jejunal ulcer would develop within an average of 2.4 months, as had occurred when we stopped treating another group of Mann-Williamson dogs with aluminum phosphate gel. But an ulcer did not develop in any of 16 dogs until eighteen to thirty months after the treatment was discontinued (table 4). This indicated that the enterogastrone preparation gave some sort of resistance which endured for some time after the cessation of treatment.[50] The data in table 4 show that an extract made from muscle had no protective effect; also that the enterogastrone preparation given parenterally for three months provides some protection. This phenomenon of protection and enduring resistance has been observed by Sandweiss and his associates [51] to be true of an extract made from human urine.

More recently it has been found by Dr. Grossman that a preparation made from the intestinal mucosa offers protection and resistance against the development of ulcers when given orally to Mann-Williamson dogs.

Though the war retarded the investigation of the injectable product in the prevention of recurrences in human patients, 58 patients have been treated. Thirty-

TABLE 4.—*Results of Treatment of Mann-Williamson Dogs*

Experiment	Procedure	No. of Dogs	No. with Ulcer	% Ulcer	Comment
1	Control	114	112	98.2	Survival time of those in which ulcer developed 1 to 9 mo., average 3.5 mo.
2	ALPOs gel 4 × day for 1 yr	23	3	13.0	Survival time of those in which ulcer developed 2 to 9 mo., average 5.2 mo.
	Stopped ALPOs gel	10	10	100.0	Ulcer developed in from 1 to 4 mo., average 2.4 mo.
3	Enterogastrone parenterally, 1 yr	33	7	21.0	Treated for 1 yr., then treatment was stopped
	After stopping treatment	16	...	....	11 died without ulcer in 12 to 46 mo.; 3 died with ulcer in 18 to 30 mo.; 2 still alive at 34 and 56 mo.
4	Muscle extract control	10	10	100.0	Survival time 1.25 to 4.5 mo., average 4 mo.
5	Enterogastrone parenterally, 3 mo.	10	3	33.0	Treated for 3 mo. and then treatment was stopped
	After stopping treatment	7	...	....	6 died without ulcer in 1 to 23 mo., average 13 mo.; 1 still alive at 30 mo.
6	Extract orally	20	4	20.0	4 died with ulcer, average 5 mo.; 3 died without ulcer, average 6 mo.; 4 still under treatment
	Treatment stopped at 9 mo.	9	...	....	1 died without ulcer at 7 mo. after treatment; 8 alive 2 to 14 mo. after treatment

48. Dragstedt, L. R., and Schafer, P. W.: Surgery **17**: 742, 1945. Thornton, T. F.; Storer, E. H., and Dragstedt, L. R.: Supradiaphragmatic Section of Vagus Nerves, J. A. M. A. **130**: 764 (March 23) 1946. Dragstedt, L. R., and Owens, F. M., Jr.: Proc. Soc. Exper. Biol. & Med. **53**: 152, 1943. Dragstedt, L. R.: Ann. Surg. **122**: 973, 1945. Dragstedt, L. R.; Palmer, W. L.; Schafer, P. W., and Hodges, P. C.: Gastroenterology **3**: 450, 1944. Weinstein, V. A.; Colp, R.; Hollander, F., and Jemerin, E. E.: Surg., Gynec. & Obst. **79**: 297, 1944. Moore, F. D.; Chapman, W. P.; Schulz, M. D., and Jones, C. M.: New England J. Med. **234**: 241, 1946. Barron, L. E., and Curtis, G. M.: Effect of Vagotomy on Gastric Motor Mechanism of Man, Arch. Surg. **34**: 1132 (June) 1937.

49. Schiffrin, M. J., and Ivy, A. C.: Physiology of Gastric Secretion, Particularly as Related to the Ulcer Problem, Arch. Surg. **44**: 399 (March) 1942.

50. Ivy, A. C.: Federation Proc. **4**: 222, 1945.

51. Sandweiss, D. J.: Gastroenterology **1**: 965, 1943.

two patients have been injected with the enterogastrone preparation three times a week. Three of these patients had a jejunal, 1 a duodenal and gastric and 28 a duodenal ulcer. The duration of their history of ulcer ranged from five to fifteen years, and they had at least one definite recurrence each year; most of them had intermittent distress monthly throughout each year while on "lax" ambulatory management. The 32 patients have been treated for from two to twelve months. Twenty-four of the 32 have been asymptomatic since the treatment was started. Twenty-two of 23 have been asymptomatic for from one to twenty-seven months since the treatment was discontinued. I have been unable to follow 4 of the 32. Roentgenograms of 20 of the 32 have manifested improvement.

Since 8 of these 32 patients had recurrences, a group of 26 patients were started on injections six times a week. One of these patients had a jejunal ulcer. 1 a gastric and duodenal and the rest a duodenal ulcer. The ulcer history ranged from five to forty-seven years. Definite recurrences occurred at least once a year, and intermittent distress occurred monthly in 9 patients on "lax" ambulatory management and in 3 on rather strict advanced, continuous Sippy ambulatory management. These 26 patients have been treated for from three to twelve months. Twenty-two of the 26 have been asymptomatic since the treatment was begun. In none of 10 who received the treatment for one year have symptoms developed for from one to twenty-eight months after stopping the treatment. Roentgenograms of 19 of the 26 have shown improvement.

Patients are now receiving the oral preparation, but there are no results to report at this time.

Obviously no conclusions are warranted at present. The results, however, are sufficiently encouraging to show that this method of attack on the problem of the prevention of recurrences of peptic ulcer is worthy of further study.

Comment: I believe that the most promising approach for the solution of the problem of the prevention of recurrences of peptic ulcer is to find some therapeutically practical and innocuous method for increasing the resistance of the mucosa to injury and for completely blocking the parietal cell.

SUMMARY

1. The available evidence indicates that in approximately 1.5 million people in the United States above the age of 30 years peptic ulcers develop during a period of ten years. Ten per cent of the population will have the disease develop during their lifetime according to the present rate of incidence of the disease.

2. A study of necropsy mortality and clinical records shows that a shift in the location and sex ratio of the disease has occurred during the past century. This is evident in the data since 1920, since which time the shift cannot be justifiably ascribed to increased recognition.

3. The evidence is insufficient to explain categorically any of the following factors in the natural history of the disease: the location of the ulcer and the relation of sex, age and seasons to its incidence, onset or recurrence.

4. At present one can state with confidence that there is only one type of ulcer which occurs in man, the counterpart of which has been produced experimentally. This is the postoperative gastrojejunal ulcer which is caused chiefly by acid acting on the jejunal mucosa, which is more susceptible to acid than the gastric and duodenal.

5. The difference between the rate of healing of an acute ulcer produced by excision and that of a "chronic" peptic ulcer is that in most ulcer patients "favorable conditions" are required for prompt healing.

6. Physical and mental rest is an important "favorable condition" for healing of the "chronic" peptic ulcer.

7. None of the three propositions on which are based the view that dysphoric states cause peptic ulcer has been proved. These three propositions are: (1) that the peptic ulcer patient has a characteristic personality pattern or dysphoria; (2) that certain emotional states regularly induce gastric hyperactivity, and (3) that a state of gastric hyperactivity alone can cause peptic ulcer.

8. It is believed that the principles for the management of the exacerbations of the disease are complete and satisfactory.

9. The problem in peptic ulcer is to prevent recurrences. The surgical methods for the prevention of recurrences are to be considered as stopgaps, to be used until some more effective medical method is discovered.

10. It may be hoped that future research will reveal some innocuous means for rendering the gastric, duodenal and jejunal mucosa less susceptible to injury and for completely blocking the parietal cell.

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AMNESIA DURING PARTURITION

Use of Pentobarbital Sodium and Scopolamine Hydrobromide

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The need for some form of relief of pain during parturition is admitted by most obstetricians and desired by all women in labor. The abundance and variety of methods and agents described in the medical literature in an attempt to accomplish such an end serve only to stress the need for improvement. It is admitted from the start that the method to be described is not a panacea. However, in the hands of my associates and me it has been proved to be efficacious, simple and safe for both the mother and the fetus.

The combination of pentobarbital sodium and scopolamine hydrobromide as agents for the production of amnesia during the first and second stages of parturition has well proved its value.[1] However, practically all

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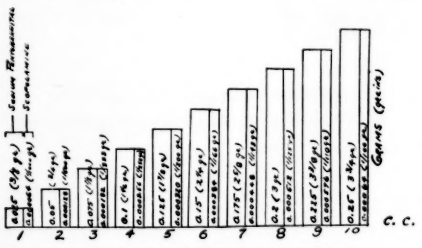
Read before the Section on Anesthesiology at the Ninety-Fifth Annual Session of the American Medical Association, San Francisco, July 4, 1946.

1. (*a*) Graham, J. D.: Nembutal "844" in Obstetrics, Journal-Lancet **51:** 470-471 (Aug. 1) 1931. (*b*) Lundy, J. S.: Experience with Sodium Ethyl (l-Methylbutyl) Barbiturate (Nembutal) in More Than Two Thousand Three Hundred Cases, S. Clin. North America **11:** 909-915 (Aug.) 1931. (*c*) Galloway, C. E., and Smith, P. H.: Pentobarbital Sodium and Scopolamine for Relief of Pain in Five Hundred Deliveries, Am. J. Obst. & Gynec. **29:** 207-215 (Feb.) 1935. (*d*) Boylan, J. P.: Pentobarbital Sodium Analgesia with a Report of Two Hundred and Five Cases, ibid. **29:** 440-443 (March) 1935. (*e*) Averett, L.: Nembutal and Scopolamine Analgesia in Labor with a Report of One Hundred and Sixty Cases, ibid. **27:** 109-112 (Jan.) 1934. (*f*) McNeal, A.; Bauer, C. P., and Sanford, H.: Sodium Pentobarbital and Scopolamine Analgesia in Labor, Anesth. & Analg. **13:** 111-115 (May-June) 1934. (*g*) McGuiness, F. G.: Relief of Pain in Labor with Nembutal, Canad. M. A. J. **30:** 162-164 (Feb.) 1934. (*h*) Parker, J. D.: Pentobarbital Sodium as Obstetrical Analgesic, J. South Carolina M. A. **31:** 210-212 (Nov.) 1935. (*i*) Edwards, W. C.: Pentobarbital-Sodium Analgesia in Obstetrics in Home, J. A. M. A. **108:** 957-959 (March 20) 1937. (*j*) Galloway, C. E.; Grier, R. M., and Blessing, R.: Pentobarbital Sodium and Scopolamine Hydrobromide: Three Years' Experiences with These Drugs in Obstetrics at Evanston Hospital, ibid. **107:** 1707-1710 (Nov. 21) 1936. (*k*) Frech, H. C., Jr.; Volpitto, P. P., and Torpin, R.: Amnesia in Obstetric Practice, J. M. A. Georgia **28:** 147-153 (April) 1939. (*l*) Hanley, B. J.: Obstetric Analgesia (with Pentobarbital Sodium and Scopolamine) in Private Patients, Am. J. Surg. **54:** 403-406 (Nov.) 1941.

experiences with these agents in the past have been with the oral or rectal administration of the pentobarbital sodium and the hypodermic administration of the scopolamine hydrobromide.

The oral route of administration of the barbiturates in obstetric patients has proved to be pure guesswork. This is true from the standpoint not only of dosage but also of whether or not the agent will be adequately and quickly absorbed. A full stomach or an altered p_H of its contents might easily upset any degree of absorption. These same objections may apply to rectal routes of administration. The outcome not infrequently results in an overdosage of the drug to the mother and, as a direct consequence, in a higher incidence of apneic newborn infants. A failure to get an adequate effect, either because the drug is not absorbed or because the amount is insufficient, also was experienced. In obstetric patients having a precipitate labor, as is the case in many multiparas, there is not time in many instances for the drugs, if given, to have their full effect. If too small a dose is given or if the stomach is full, time will not allow for further sedation.

Late in 1941 the intravenous use of pentobarbital sodium and scopolamine hydrobromide to induce amnesia in obstetric patients was initiated by the department with which I am connected. In a recent survey of the literature it was interesting to note three reports. In December 1932 W. F. Abbott [2] described excellent results with the intravenous use of pentobarbital sodium alone in a series of 75 patients in labor. In June 1944 John R. Evans [3] reported the successful intravenous use of vinbarbital sodium for the induction of obstetric amnesia in 1,500 patients. In 1946 Lewis [4] reported the intravenous use of vinbarbital sodium for amnesia, analgesia and anesthesia in obstetrics.



Dilutions of pentobarbital sodium and scopolamine.

Pentobarbital sodium and scopolamine hydrobromide have been used intravenously in the University Hospital in over 1,000 obstetric patients during the past four years. Of this large group, 170 patients were followed closely enough to warrant this report.

METHOD

(The object is amnesia, not analgesia or anesthesia!) The contents of a pentobarbital sodium (0.25 Gm. [3¾ grains]) ampule and a scopolamine hydrobromide (0.00064 Gm. [1/100 grain] ampule are mixed and diluted to a 10 cc. capacity with sterile distilled water. Each cubic centimeter of this dilution contains 0.025 Gm. (¾ grain) of pentobarbital sodium and 0.00064 Gm. (1/1000 grain) of scopolamine hydrobromide (chart). (Hereafter, to avoid confusion, the dosage of these drugs will be expressed in cubic centimeters.)

In any normal primipara or multipara, as soon as regular pains develop four to five minutes apart and last at least thirty or more seconds, the combination of the aforementioned drugs is given intravenously. A 10 cc. syringe with a small, 27 to 22 gage, needle is employed. An initial 3 or 4 cc. of the mixed agents is given fairly rapidly, at the rate of 1 cc. every five to ten seconds; then the injection is slowed to the rate of about 1 cc. every thirty seconds until the patient either begins to fall asleep or talks incoherently. At this point the injection is stopped, but the needle is kept in place and the patient is watched during a uterine contraction. If she is extremely restless during this pain and talks coherently, an additional 1 to 3 cc. at the most is administered. On the other hand, if the patient is slightly restless or opens her eyes and talks incoherently, no further amount of the mixture of drugs is given and the needle is withdrawn.

The average patient, whether primapara or multipara, will require a total initial injection of 10 cc. of the mixture. As little as 6 cc. and as much as 20 cc. has been found necessary in some instances. A patient whose cervix is fully dilated and who is beginning to bear down with each pain may require greater initial or additional amounts; however, one should be extremely cautious at this time, as it is amnesia, not analgesia, that one is seeking; hence one should expect more restlessness at this time and, naturally, incoherence. Care must be taken not to mistake momentary lucid intervals, such as recognition by the patient or the request for relief of pain, as time for administration of more drugs. A nurse or attendant should watch the patient for restlessness or need for more drugs.

After the initial induction of amnesia, the frequency and amounts of further injections will depend on the particular patient and the progress of labor. When the patient tends to become restless during the pain or does not sleep and is somewhat lucid between uterine contractions, then administration of more of the drugs is indicated. This will generally occur about three-fourths to one hour after the initial injection in the average patient and usually will require use of not more than 2 cc. of the dilution of amnesic drugs intravenously. The average multipara, unless the cervix is fully dilated at the beginning, may need one such injection (2 cc.) repeated and the average primipara about three such injections. The interval between the need of additional amounts grows longer with each injection, e. g., one hour for the first, two hours for the second and three to four hours before need for a third.

RESULTS

Cases of 170 patients comprise this report, although over 1,000 women in labor were delivered during a four year period with the intravenous use of pentobarbital sodium and scopolamine hydrobromide for induction of amnesia.

This group is composed of white and Negro women from both the charity and the private services of the University Hospital. In this group of 170 patients there were 75 primiparas and 95 multiparas. One hundred and sixty-four (96.4 per cent) of the women

2. Abbott, W. F.: Nembutal (Pentobarbital Sodium): Intravenous Use During Labor, Canad. M. A. J. **27**: 620-623 (Dec.) 1932.
3. Evans, J. R.: Vinbarbital: Intravenous Administration for Induction of Obstetric Amnesia, Am. J. Obst. & Gynec. **47**: 821-825 (June) 1944.
4. Lewis, M. S.: Vinbarbital Sodium for Obstetric Amnesia, Analgesia and Anesthesia, Am. J. Obst. & Gynec. **51**: 395-402 (March) 1946.

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delivered spontaneously, and 6 had low forceps deliveries. One hundred and fifty-two, or 89.4 per cent, of the patients reported complete amnesia (i.e., no events whatsoever were recalled after the initial induction of amnesia). Eighteen, or 10.6 per cent, reported partial amnesia, i.e., they were able to recall some isolated phases of the labor.

PROGRESS OF LABOR

In 18 (10.6 per cent) of this group there was an apparent slowing of either or both first and second stages of labor. In 5 (2.9 per cent) of this series labor pains ceased completely after the administration of the drugs, no further barbiturate-scopolamine mixture was given and the patient was allowed to deliver without benefit of amnesia.

Maternal Morbidity and Mortality.—Three of the women (1.7 per cent) became extremely excited and almost unmanageable. This occurred during the early second stage, and all of them were controlled by the administration of ⅛ grain (0.0075 Gm.) of morphine sulfate intravenously. Thirty-four (20 per cent) of the patients became exceedingly restless during the later part of the second stage and were fairly well controlled by an additional 1 to 3 cc. of the pentobarbital–sodium scopolamine hydrobromide mixture. No attempt to abolish the restlessness completely was ever considered or desired. A moderate amount of restlessness with each uterine contraction was always maintained in all patients.

A severe drop in blood pressure occurred in 2 patients. This was associated with a rapid injection of the drugs intravenously by inexperienced personnel. Both patients rapidly recovered on the administration of 2 mg. of neo-synephrine hydrochloride intravenously and high concentration of oxygen by means of an anesthetic bag and mask.

Severe respiratory depression occurred in 1 patient (she showed a shallow respiratory exchange, tachycardia and cyanosis) to whom the drugs were given too rapidly and the airway was not watched closely enough. On establishment of an adequate airway and the administration of oxygen with an anesthetic apparatus, the patient, within a few minutes, began to breathe spontaneously with an adequate exchange, the pulse slowed and cyanosis disappeared.

Nausea and vomiting occurred in 3 patients (1.75 per cent) of the group and was controlled with small additional doses of the amnesic drugs.

All the observed patients awakened and were able to speak coherently within fifteen minutes to one hour after the delivery and the repair of a routine episiotomy. For the repair of episiotomy the patients were given either cyclopropane by the carbon dioxide–absorption technic or open drop ether. The technic and agents employed depended on the experience of the person giving the anesthetic.

There was one maternal death. The patient was a white primipara aged 22 years. She walked into the hospital, and the nurse recorded on her chart a temperature of 98.4 F. (oral) and a respiratory rate of 20 per minute. One hour and forty-five minutes later she was given 10 cc. of pentobarbital sodium and scopolamine hydrobromide intravenously. Labor progressed normally but rapidly, and forty minutes later she was given an additional 5 cc. of the mixture. Shortly after this the patient appeared cyanotic and dyspneic; the pulse rate was 160 and the blood pressure 70 systolic and 40 diastolic. Two hours later a high forceps delivery of a stillborn fetus was carried out. The patient died four hours after the second administration of drugs, in spite of administration of oxygen by positive pressure, cedilanid (lanatoside C isolated from Digitalis lanata) intravenously and 50 cc. of 50 per cent dextrose. (It was thought that an acute cardiac decompensation had developed.) Postmortem examination revealed a normal heart. The patient had early (first stage) lobar pneumonia involving both lungs.

Infant Morbidity and Mortality.—There were 171 babies delivered of 170 mothers. One of the deliveries was a twin birth. One hundred and fifty-seven (92.4 per cent) of the babies breathed spontaneously immediately after birth. Thirteen (7.6 per cent) were born apneic and were given endotracheal insufflation of air, the Torpin insufflator[5] being employed. Twelve of this group were successfully resuscitated. It is interesting to note that 5 babies with depressed respiratory tracts were born to mothers who had been given ⅛ to ¼ grain (0.01 to 0.15 Gm.) of morphine sulfate subcutaneously one to four hours before delivery in addition to the barbiturate and scopolamine hydrobromide. Uterine inertia had been present in these cases. One of the 13 babies died after ten minutes of attempted endotracheal insufflation of air. This child weighed 4 pounds 9 ounces (2069 Gm.) at birth. Labor was extremely rapid. Five cubic centimeters of the drugs was given to the mother twenty-six minutes before delivery.

There was 1 stillborn infant in the series. This infant was born to the patient who died of lobar pneumonia complicated by the administration of pentobarbital sodium and scopolamine hydrobromide.

COMMENT

It must be emphasized that pentobarbital sodium is primarily a hypnotic agent. In safe dosages it lacks completely analgesic or anesthetic potentialities. Pentobarbital sodium combined with scopolamine hydrobromide is capable of producing excellent amnesia.

There have been no authenticated reports in the literature of maternal deaths directly attributable to pentobarbital sodium and scopolamine hydrobromide when these agents were used judiciously. The maternal death reported in this series might have been avoided if the presence of lobar pneumonia had been discovered on admission of the patient to the hospital. It is conceded that barbiturates should not be employed (1) in patients with evidence of pulmonary disease, (2) in debilitated persons, (3) in toxic patients, (4) in asthmatic persons and (5) in patients with hepatic damage, suspected or real.

The high incidence of spontaneous breathing in the newborn infants of this series (92.4 per cent, corrected to 95.9 per cent on exclusion of the 5 cases in which administration of morphine sulfate complicated the amnesia) adds further evidence to the impression that nonanesthetizing doses of pentobarbital sodium do not depress the respiratory center of the fetus. This also is in keeping with the experimental evidence reported

5. Volpitto, P. P., and Torpin, R.: Apnea Neonatorum: Its Treatment by a Simplified Insufflation Technique, South M. J. **35**: 550-564 (June) 1942.

by Hamilton, Woodbury and Torpin.[6] These investigators found pentobarbital sodium and scopolamine hydrobromide to be among the drugs which when given during active labor increased the active maternal arterial pressure to the placenta.

The high incidence of spontaneous deliveries (96.4 per cent) adds evidence to the clinical impression that the second stage of labor is shortened. Experimentally, Hamilton, Woodbury and Torpin [6] found that pentobarbital sodium (administered orally) and scopolamine hydrobromide (given hypodermically) did inhibit the action of the maternal abdominal muscles in the second stage of labor. However, this was only a temporary delay, as it returned later in the second stage and the patient delivered spontaneously. This experimental work needs to be repeated with the drugs given intravenously. It is our impression that if these drugs are not given too early in labor and only in amnesic dosages labor usually is not delayed and spontaneous delivery occurs. The recent report of Lewis [4] on the use of vinbarbital sodium intravenously, with or without scopolamine hydrobromide, in obstetrics is interesting. Lewis attempts to obtain analgesia and anesthesia with a primary agent (vinbarbital sodium) poorly suited for such a task unless the bounds of safety are encroached on for both the mother and the fetus.

Finally, it must be stressed that a desirable prerequisite is a cooperation between obstetrician, patient and physician experienced in the use of any agent or technic for the relief of pain in obstetrics. In such circumstances no routine method need be applied. The choice of agents or technics depends on the obstetric problem at hand.

CONCLUSIONS

Intravenous use of pentobarbital sodium and scopolamine hydrobromide has proved to be, in our experience, an efficient and safe method for obtaining satisfactory amnesia during parturition.

The safety and success of the method described will depend on the experience and ability of the person employing it.

The technic described is offered as another method to be judiciously employed in the armamentarium for relief of pain during labor. It is not intended to replace or displace any safe methods now in use.

ABSTRACT OF DISCUSSION

Dr. John A. Moffitt, Los Angeles: One of the principal advantages of the intravenous administration of pentobarbital sodium over the oral method in the obstetric patient is its controllability. The desired effect may be obtained more rapidly, and when this is reached the injection is stopped; it is again resumed when signs of amnesia begin to wear off. Patients differ greatly in the amount of the drug necessary, and there is less likelihood of administering too large or even too small a dose when the intravenous method is used. The barbiturates are metabolized more rapidly when given intravenously and there is less danger of a cumulative effect, especially when a large amount is necessary toward the end of the first stage of labor. Occasionally, patients have an idiosyncrasy to barbiturates, and it is a distinct advantage to be able to stop the administration at once, as such symptoms would appear soon after a small amount had been given. This is possible only by the intravenous use. Many obstetric patients have food in their stomachs when labor begins. Digestion is retarded, and the food remains in the stomach longer than normally, retarding absorption of drugs taken by mouth. Vomiting may occur, with loss of all or part of the orally administered medicament, rendering it difficult to determine how much of the drug the patient will need. If given intravenously, not only is none of it lost if there is vomiting but vomiting is less likely to occur. Sometimes it is necessary to use an opiate in conjunction with pentobarbital sodium and scopolamine hydrobromide, either to quiet the excitable patient or to control the extremely severe pain which may occur. Meperidine hydrochloride (Demerol) seems preferable to morphine sulfate, with less depressing effect on the respiration of the babies, more of whom, at least in our experience, cry spontaneously. One principal disadvantage of using pentobarbital sodium and scopolamine hydrobromide intravenously is that it requires more constant attendance of a physician, which, however desirable, is not always possible, especially in private practice. While oral administration of pentobarbital sodium and intramuscular administration of scopolamine hydrobromide may be done by a nurse, many hospitals do not permit nurses to give drugs intravenously, and it would be necessary for the obstetrician or the anesthetist to be present much earlier if this method were used. The advantages of the technic described by Dr. Volpitto so far outweigh the disadvantages that I believe there is a definite place for it and feel sure that many patients are better cared for under this method than with some of the others commonly employed.

Dr. Walter Lawrence, San Francisco: There is an excellent feature in Dr. Volpitto's paper which is extremely satisfying to me. He has repeatedly stressed the importance of restricting the dosage of the intravenously administered barbiturate-scopolamine-hydrobromide combination rigidly within safe limitations. Nevertheless, one is led to speculate as to how often the administration of the drugs will be improperly crowded when the presence of an anxious husband or mother in the labor room upsets the anesthetist's judgment. I can testify as to the dangers of the oral administration of barbiturates during labor. During one year in the hospital with which I am connected we had deaths of 5 infants due to atelectasis in about five hundred deliveries. In all the cases barbiturates were given orally to the mothers in what I considered excessive doses; these were sometimes combined with morphine sulfate. I have always been opposed to this uncertain and dangerous method, and it has been largely abandoned. If I can make a contribution to this paper, it would be to express, as I do almost daily to the hospital staff, my severe disapproval of attempts to block completely the reflex arc by the intravenous use of the barbiturates. These drugs produce a progressive descending depression and will not completely abolish the reflex arc and its reflex activity until a dangerous oversaturation of the higher centers has been produced. If Dr. Volpitto's method falls into disrepute it will be because this limitation of the barbiturates has not been adhered to. I should like to ask Dr. Volpitto whether, in referring to pentobarbital sodium, he means the preparation having the oxygen on the no. 2 carbon of the molecule. I am sure that others, like myself, when they see the prefix "pento-" immediately think of pentothal sodium, which is identical in every respect except that the oxygen on the no. 2 carbon is replaced by sulfur. A more distinctive terminology would prevent some difficulties with these two drugs.

Dr. Perry P. Volpitto, Augusta, Ga.: I certainly agree with Dr. Moffitt about meperidine hydrochloride. We are still not too positive about that particular point, but it is being investigated at present and I think it is something that should be considered. Regarding Dr. Lawrence's worry about the father and mother of the patient: In our particular institution when patients are in labor they are put in the labor room and relatives are not allowed in the vicinity. I think that is about the only way to get rid of some one "getting into your hair," as it were. As to whether it is the oxygen molecule or the sulfur in the no. 2 position, it is the oxygen. If it were the sulfur, this would make it a thiopentobarbital and it would be pentothal sodium instead. This is pentobarbital sodium, more commonly known by the trade name of Nembutal.

6. Woodbury, R. A.; Hamilton, W. F., and Torpin, R.: The Relationship Between Abdominal, Uterine and Arterial Pressures During Labor, Am. J. Physiol. **121**: 640-649 (March) 1938.

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INCIDENCE OF URINARY CALCULI IN THE AMERICAN NEGRO

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It is generally conceded that some races have a higher incidence of urinary calculi than others. The Negro is generally believed to be particularly immune to this disease. J. Swift Joly [1] in discussing the etiology of stone made the following statement: "On turning to the racial incidence of lithiasis, one is struck by the comparative immunity of the Negro. This, I believe, still holds good in the case of the Negro population of America which has received no fresh blood from Africa for almost a century." Holmes and Coplan [2] wrote that only 1 case of urolithiasis in a Negro was seen at the James M. Jackson Memorial Hospital in Miami, Fla., during a five year period. This is of particular interest, since, according to the same authors, the incidence of calculi is particularly high in southern Florida.

Reaser [3] commented on the infrequent occurrence of urolithiasis in patients coming to autopsy at St. Elizabeth's Hospital, Washington, D. C. In 5,900 autopsies, 70 cases of calculi were found, only 14 of which were in Negro patients. The total number of Negro patients was not available, therefore a percentage ratio could not be determined. Ezickson,[4] in a study of the relationship of urinary tract infections to urolithiasis in 134 patients who had or had had stones, found only 4 Negroes in the entire group. Although he stated that Negroes comprised a substantial portion of the general admissions, a definite ratio was not given.

Few comparisons of the incidence of urolithiasis in the white and Negro races have been published. Day [5] published a comparison of the urologic diseases in white and Negro patients admitted to the Louisville General Hospital from June 1, 1916 to April 1, 1920. Calculi were found three times as often in the white as in the Negro patients. He mentioned a similar report by Matas, who compared admissions to the Charity Hospital in New Orleans from 1884 to 1894. Only bladder stones were mentioned, but the ratio was also 3 to 1. Cary [6] analyzed the admissions to several hospitals in the mid-Atlantic area of the United States. The analysis indicated that cases of urolithiasis in this area are from three and one-half to five times as frequent in white persons as among Negroes (table 1). Quinland [7] reported 33 cases of urinary calculi occurring in 1,019 autopsies and 14,900 pathologic specimens collected from Negro patients admitted to the George W. Hubbard Hospital, Nashville, Tenn., during a period of twenty-two years. This report suggests a much lower incidence than Cary's report but represents only patients admitted to one relatively small hospital. Vermooten [8] commented on the extreme rarity of renal calculi in the South African Negro and called attention to mortality statistics for the United States of America Registration Area which show that deaths from renal calculus per million population are as follows: white males 9 and colored males 7; white females 4.1 and colored females 2.7. These statistics indicate a higher incidence in the Negro than that reported by Cary, but an analysis of our patients and of those reported by Quinland indicates a higher mortality from renal calculi among Negroes than in the white race.

TABLE 1.—*Analysis of Frequency of Urolithiasis in Several Hospitals in the Mid-Atlantic Area of the United States*

	Admissions		All Urinary Stones: Cases		All Urinary Stones: Per Cent of Admissions		All Urinary Stones: Ratio	Renal and Ureteral Stones: Cases		Renal and Ureteral Stones: Per Cent of Admissions		Renal and Ureteral Stones: Ratio
	W	N	W	N	W	N	W/N	W	N	W	N	W/N
* Johns Hopkins Hospital, Baltimore	46,787	18,656	269	33	0.639	0.177	3.61	239	27	0.554	0.145	3.81
† University Hospital, Charlottesville, Va.	27,965	5,833	185	14	0.662	0.240	2.76	161	9	0.576	0.155	3.73
Medical College, Richmond, Va.	24,310	18,378	116	30	0.477	0.163	2.93	108	27	0.444	0.147	3.05
Duke Hospital, Durham, N. C.	27,481	5,165	390	34	1.42	0.658	2.16	364	32	1.325	0.620	2.14
Total	126,543	48,032	960	111	0.782	0.231	3.39	892	95	0.705	0.198	3.56
	Population											
‡ Richmond, Va.	167,374	61,191	346	24	0.207	0.039	5.27	318	23	0.19	0.038	5.06

* Due to a change in the recording system during the time of this study, we cannot be sure that we found every case. The consecutive history numbers make us believe that we missed relatively few, and probably the same proportionality holds in those we missed.
† No separate record kept of admissions. From averages taken eight times on 2,000 consecutive admissions at every season during the five year period, the Negro admissions were 17.26 per cent of the total.
‡ Chamber of Commerce population figure for "metropolitan area."
Reprinted by permission from the Journal of Urology.[6]

To a separate comparison of the incidence of urolithiasis in the Negro and white races, Cary [6] added a comparison of the incidence of urolithiasis in the Negro and white races in the Medical College of Virginia. The frequency with which we encounter calculi of the urinary tract on the wards of the Hospital Division of the Medical College of Virginia convinces us that although urolithiasis may occur less frequently in the Negro than in the white race, it is by no means uncommon. Furthermore, we have observed that stones in the Negro are more frequently accompanied with infection and are far more destructive to renal tissue than those in white patients. The fact that Negroes are more reluctant to seek medical aid and depend more on home remedies than do white people certainly contributes to some extent to higher morbidity and mortality as a result of stone. The same thing doubtless contributes to the fact that calculi are less frequently found among them.

So far as race is concerned in the etiology of stones, the American Negro seems to occupy a unique position. According to Joly [9] "countries which have been colonized by Anglo-Saxons, such as North America or

From the urological service of the Hospital Division, Medical College of Virginia.
Read before the Section on Urology at the Ninety-Fifth Annual Session of the American Medical Association, San Francisco, July 3, 1946.

1. Joly, J. S.: The Etiology of Stone, J. Urol. **32**: 541 (Dec.) 1934.
2. Holmes, R. J., and Coplan, M. M.: Geographic Incidence of Urolithiasis, J. Urol. **23**: 477 (April) 1930.
3. Reaser, E. F.: Racial Incidence of Urolithiasis, J. Urol. **34**: 148 (Aug.) 1935.
4. Ezickson, W. J.: The Relationship of Urinary Tract Infection to Urolithiasis, J. Urol. **51**: 431 (April) 1944.
5. Day, G. H.: Urologic and Venereal Idiosyncrasies Presented by the Negro, J. Urol. **5**: 19 (Jan.) 1921.
6. Cary, M. K.: The Racial Incidence of Urolithiasis, J. Urol. **37**: 651 (May) 1937.
7. Quinland, W. S.: Urinary Lithiasis: Review of Thirty-Three Cases in Negroes, J. Urol. **46**: 791 (June) 1945.
8. Vermooten, V.: The Occurrence of Renal Calculi and Their Possible Relation to Diet as Illustrated in the South African Negro, J. A. M. A. **109**: 857 (Sept. 11) 1937.
9. Joly, J. S.: Stone and Calculous Disease of the Urinary Organs, St. Louis, C. V. Mosby Company, 1940.

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Oceana, do not show as high a stone incidence as the parent state. The same applies to South America, which is largely colonized by Spain and Portugal. Stone is practically unknown in this continent, but it is not uncommon in Spain." Contrary to this, the Negro, who, according to all reports, seems rarely to suffer from urinary calculi in his native land, within two hundred years of his arrival in North America is stricken with this disease at least one fourth as often as are members of the white race. The admixture of Caucasian blood has been mentioned as a possible factor in the causation of stone in the Negro, but from the physical appearance of many of our patients it is doubtful that this is of much importance.

Vermooten has stated that the South African Negro subsists on a diet low in calcium, with an acid ash base and a high vitamin A content. He also commented on the densely calcified bony structure and the freedom from dental caries among these people.

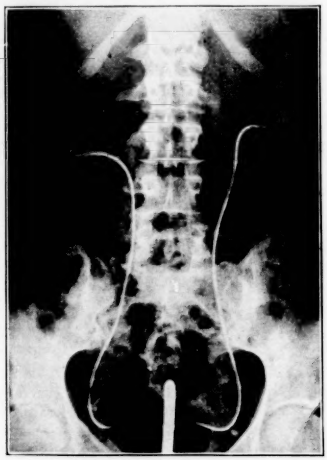

Fig. 1.—Multiple bilateral calculi.

So far as we can determine, the diet of the Negroes in our community differs little, if any, from that of white people of similar income, and an examination of 67 Negro patients recently admitted to the Hospital Division of the Medical College of Virginia showed that 23 had carious teeth. Thirteen of these patients also had pyuria, varying from ten to numerous cells to the field. These factors may play some part in the more frequent occurrence of stones in the American Negro.

Since the Negro race does seem to enjoy a natural immunity to urolithiasis, and since those of the race who have migrated to North America seem at least in part to have lost that immunity, a careful study of the problem among the Negroes of America should throw some light on the complex problem of the etiology of this disease. It is with the hope of stimulating such investigation that an analysis of our patients is presented.

During the ten year period from 1935 until 1946 there were 2,724 white patients and 1,800 Negro patients admitted to the urologic service of the Hospital Division of the Medical College of Virginia. Of these, 637 white patients and 121 Negro patients had urinary calculi. Five urologists are privileged to treat patients on the private floors of the hospital for white patients, while relatively few Negro patients secure private accommodations. Elimination of private patients would greatly alter this ratio. The distribution of stones in the Negro is similar to that usually reported in white patients. There were 62 patients with renal calculi, 52 with ureteral calculi and 20 with stones in the bladder (table 2). (The apparent discrepancy in the number of these patients and in the total mentioned previously results from the fact that several patients had stones in both kidney and ureter or in the kidney and bladder.) The incidence as to age is likewise similar to that in white patients (table 3). The laboratory data illustrated in table 4, while in many instances incomplete, indicate a decided departure from the laboratory results we usually see in white patients. Approximately half of the patients have alkaline urine. Of 67 Negro patients admitted consecutively to the

TABLE 2.—*Distribution of Calculi*

Stone in right kidney	18
Stone in right kidney and ureter	2
Stone in right kidney and bladder	1
Stone in left kidney	17
Stone in left kidney and ureter	4
Stone in left kidney and right ureter	3
Stone in left kidney and bladder	2
Stone in both kidneys	15
Stone in right ureter	27
Stone in right ureter and bladder	1
Stone in left ureter	15
Stone in bladder	16

TABLE 3.—*Age and Sex*

Males.....73	Females.....48
Age	Patients
10 to 20	6
20 to 30	24
30 to 40	24
40 to 50	26
50 to 60	19
60 to 70	17
70 to 80	4
80 to 90	1

TABLE 4.—*Laboratory Reports*

Urinalysis	**Phenolsulfonphthalein**	**Nonprotein Nitrogen**
Reaction	Diminished (15 of these had elevated nonprotein nitrogen) 33	Normal 60
Acid 49	Normal 38	Elevated 20
Alkaline 54	Not mentioned 50	Not mentioned 41
Not mentioned 18	**Hematology**	**Wassermann**
Albumin	Mild anemia 34	Positive 16
Present 69	Severe anemia 6	Negative 61
Not present 32	Normal 81	Not mentioned 44
Not mentioned 20	**Bacteriology**	**Analysis of Stones**
Leukocytes	E. coli 4	Calcium oxalate 8
Rare to few 62	B. lactis aerogenes 5	Calcium carbonate 9
Numerous to abundant 35	P. vulgaris 2	Calcium phosphate 11
Not mentioned 24	Staph. albus 1	Triple phosphate 5
Red blood cells	S. faecalis 1	Ammonium nitrate 1
Present 62	Gram-negative diplococcus 1	Mixed calcium 1
Not mentioned 59	Not mentioned 107	Uric acid 2

medical service of the Hospital Division of the Medical College of Virginia, 18 had alkaline urine on admission and 7 had pronounced pyuria. The relationship of alkaline urine and infection to urolithiasis in the Negro is further illustrated in the analysis of stones, which shows that a great majority are of the alkaline variety (figs. 1 and 2). Almost a third of our patients had rather severe infection of the urinary tract, and the renal function tests indicated a high percentage of renal damage. Forty of these patients had some degree of anemia and 16 had a positive Wassermann test.

Twenty-six of these patients had been previously admitted to the hospital for some disease of the urinary tract, the majority of them because of stone (table 5). This high incidence of readmission results to a large extent from the reluctance of the Negro, in many instances, to submit to an operation and to the difficulty of persuading him to return for adequate postoperative

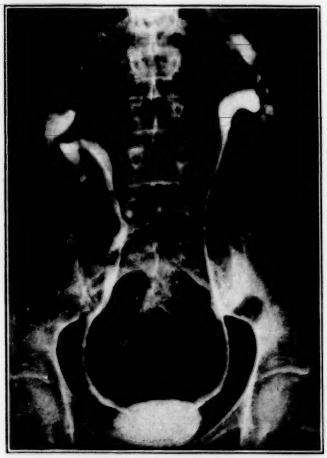

Fig. 2.—Pyelogram, same case as figure 1.

treatment. Once free of pain he is rarely seen until he is again incapacitated.

The treatment varies considerably from that usually considered advisable in white patients (table 6). The percentage of nephrectomies is extremely high. It was required in 20 of the 62 patients with stone in the kidney, while only 26 of 190 white patients with renal calculi treated by me in a small private hospital during the same period required nephrectomy. This is partly accounted for by the fact that conservative surgery is frequently not as successful in Negro as in white patients. Most of the renal calculi in Negroes are phosphatic; renal damage is considerable before the patient applies for treatment, and he will seldom submit to the tedious regimen desirable after conservative operations. The large number of nephrolithotomies as compared with pyelotomies is further evidence of a more severe type of calculosis. Fourteen of these patients had staghorn calculi and 10 had multiple calculi in the kidney. Four patients admitted with far advanced renal infection and bilateral calculi died of uremia and sepsis within a few days. Deaths did not occur among the 50 patients treated for stone in the ureter. Operation was performed on a rather large percentage of these. Negro patients are not willing to persist in efforts to remove ureteral calculi by cystoscopic methods to the same extent as are the white patients and will frequently

TABLE 5.—*Previous Admissions*

	Patients	Treatment	
Stone in kidney	5	Nephrolithotomy	3
		Nephrectomy	2
Stone in ureter	5	Ureterolithotomy	3
		Cystoscopic treatment	2
Perinephritic abscess	3	Incision and drainage	3
Pyelitis	2	Chemotherapy	2
Hypertrophy of prostate	4	Transurethral resection	4
Stone in bladder	4	Litholapaxy	3
		Cystotomy	1
Rupture of bladder	1	Suprapubic cystotomy	1
Stricture of urethra	2	External urethrotomy and incision of stricture	2

leave the hospital against advice when their pain is relieved. Furthermore, the Negro patient cannot be depended on to return at regular intervals for ureteral manipulations.

The highest operative mortality was in the group of patients with stones in the bladder. With 3 exceptions—1 following injury to the bladder and 2 complicated by stricture of the urethra—they were all elderly persons. Ten of them were also operated on for hypertrophy of the prostate. There were 2 women, both of whom had large cystoceles.

It is not wise to draw any definite conclusion from a small group of patients in a limited area, but from our experience it is evident that urolithiasis is not an unusual condition in the American Negro. Whatever natural immunity the Negro may have is certainly modified by his mode of living and the frequent occurrence of infection in the urinary tract. From our observations the Negro presenting himself with stones in the urinary tract has a high incidence of alkalinuria and infection.

TABLE 6.—*Treatment*

		Well or Improved	Not Treated	Died
Kidney				
Nephrectomy	20	19	..	1
Nephrolithotomy (bilateral)	14	13	..	1
Pyelolithotomy	9	9	..	..
Signed release	5	..	5	..
Treatment not advised	14	..	10	4
Ureter				
Ureterolithotomy	21	21	..	..
Cystoscopic treatment	17	17	..	..
Stone passed spontaneously	8	8	..	..
Signed release	4	..	4	..
Bladder				
Cystotomy	9	7	..	2
Litholapaxy	9	8	..	1
Signed release	2	..	2	..

Most of the stones are of the alkaline variety. The distribution of the disease in Negroes as to sex and age is similar to that in the white race. Because of the difficulty in getting these patients to return for adequate follow-up treatment, more radical surgery usually is required than is necessary in the white patient.

ABSTRACT OF DISCUSSION

DR. WIRT B. DAKIN, Los Angeles: It is not exactly known why the Negro has fewer urinary calculi than the white man. At first it is difficult or impossible for foreigners to compete with natives of high altitudes or extremely cold climates. In time, nature helps the newcomer to adjust himself in the manner of a native. Is it not possible, then, that in his former home—Africa—nature provided the Negro with some special bodily mechanism or metabolism which helped to prevent urinary calculi, and that the American Negro inherits this protection? However, with better opportunities or more complete urologic investigation, calculi in the American Negro may be found to be more common each year.

DR. MONROE WOLF, New Orleans: I became interested in calculi in the Negro in 1925 when I had occasion within a period of four or five months to see at least 3 cases in the outpatient clinic of Touro Infirmary, and in the Women's Dispensary. The 1 at Touro was a Negro woman about 50 years of age; she had bilateral staghorn calculi and refused surgical intervention. The other 2 were a woman in the fifties with multiple calculi in a urethral diverticulum and a Negro woman in the forties with a calculous pyonephrosis of the kidney. I took the opportunity before leaving New Orleans to collect the statistics in the Charity Hospital over a period of twenty-one years, 1925 through 1945. In a total of 3,266 calculous patients, 2,654 were white men and women; 612 were Negro men and women, or 23 per cent more Negro than white. The population of Louisiana is approximately 1,620,000, with 65.03 per cent white as compared to 34.97 per cent, or 856,000, Negro. The incidence of 612 cases in the Negro in a total of 3,266 gives a total percentage of 18.77. The admissions of men to the hospital over this period were 257,170. The incidence of calculi among the white was 1,727, or .67 per cent of the admissions. The Negroes have only one institution to which they can go for hospitalization besides Charity Hospital in New Orleans, namely the Flint Goodridge Hospital.

There were 105 cases of bilateral renal calculi in men, 37 in the Negro—some of these were staghorn, which gives a percentage of 35.24 of the calculi in the Negro man. There were 36 cases of bilateral culculi in women, 10 in the Negro, or 27.7 per cent.

DR. VICTOR D. LESPINASSE, Chicago: One of the factors in the Negro immunity may be that the Negro is a native of a hot country, and the relation between fluid intake and fluid excretion through the skin is different in the Negro than it is in an Anglo-Saxon who comes from a colder country. It is well known that the kidney gets the last call for water when one perspires a great deal, and the urine is high in concentration and small in amount. The Negro, subject to the hot climate of Africa, may have an increased ability to conserve water, or the kidney may have greater ability to seize water; hence his urine is not as concentrated and the incidence of urinary calculi is less.

DR. AUSTIN I. DODSON, Richmond, Va.: I want to commend Dr. Wolf on his painstaking investigation and report.

Skin Grafting.—The split thickness graft has the greatest range of usefulness in the repair of skin loss of all methods of skin transplantation. Three types are to be distinguished: first, the thin split thickness graft, or Ollier-Thiersch graft; second, the intermediate split thickness graft of Blair and, third, the thick split thickness graft. These differ from one another only in the amounts of epidermis and dermis which are taken. At one time it was believed that the Thiersch graft represented merely the epidermal elements of the skin; but all authorities agree that it is somewhat more substantial than that and includes at least parts of the papillae of the skin. Its thickness is usually between 0.006 and 0.01 inch. The intermediate spit thickness graft of Blair varies from 0.012 to 0.016 inch. The thick split thickness graft is from 0.02 to 0.024 inch; it may represent from two thirds to four fifths of all the skin elements present. The intermediate and split thickness grafts have in a large measure displaced other forms of skin transplantation except in special cases.—Leveton, Albert L.: The Surgical Principles of Split Thickness Skin Grafting, *J. Bone & Joint Surg.*, October 1946.

ADDICTION TO MEPERIDINE HYDROCHLORIDE (DEMEROL HYDROCHLORIDE)

Report of Three Cases

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Numerous patients addicted to meperidine hydrochloride (Demerol hydrochloride) have been admitted to the United States Public Health Service Hospital, Lexington, Ky. Several had been addicted to opiates before becoming addicted to meperidine hydrochloride. Many used this drug and morphine sulfate concurrently. Prior to September 1946 cases of addiction to this drug had not been reported in the American literature, except in persons previously addicted to the opiates. Three cases of addiction to meperidine hydrochloride are here reported. Two patients have never been addicted to any other narcotic drug and 1 used morphine when sufficient meperidine hydrochloride was not available.

REPORT OF CASES

CASE 1.—Patient A, a white man volunteer aged 27, had sixteen abdominal operations between 1929 and 1941. He had received a proprietary preparation of the total alkaloids of opium as soluble hydrochlorides (Pantopon) and occasionally morphine sulfate as preoperative and postoperative medication. He emphatically denied experiencing positive pleasure[1] from these injections. He did not develop physical dependence on the drugs, because they were prescribed judiciously by a physician.

During an attack of catarrhal jaundice in the spring of 1945, he was given 100 mg. of meperidine hydrochloride hypodermically every four hours for six weeks. He stated that this medicament produced definitely pleasurable sensations, which were not related to the relief of his abdominal pain. He had never experienced such sensations from the opiate drugs. A "yearning" for the feeling that meperidine hydrochloride produced soon developed. As his catarrhal jaundice improved, the dosage was gradually reduced. At the time of his discharge from the hospital he was free of abdominal pain and discomfort but retained his yearning for the drug's pleasurable effects. He stated that to satisfy his desire for meperidine hydrochloride he began to malinger complaints in order to obtain it from physicians. After a month he found that his usual dose of 100 mg. every four hours was not producing the same degree of pleasure as he formerly experienced. He therefore started to increase his doses of the drug, which he obtained from narcotic peddlers and by prescriptions obtained from numerous physicians. At the time of admission to this hospital, in May 1946, he was taking between 200 and 500 mg. of meperidine hydrochloride hypodermically every three hours. The story of the results of his intense desire to obtain the drug parallels those obtained from many morphine addicts who have abandoned all socially productive enterprises and have directed all their energies to procuring morphine.

The patient described the effects of the drug as follows: "Demerol kicks me right up. It produces feelings I have never had and really desire. It relaxes my insides and I feel good. I forget my worries and feel exhilarated. All aches, pains and nervousness leave me. No other medication ever gave me this type of pleasure." He stated that meperidine hydrochloride abolished his desire for sexual experiences and that "Sexual pleasure is short-lived and easily satisfied; the pleasure obtained

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Approved for publication by the Surgeon General of the United States Public Health Service.

1. Kolb defined positive pleasure as a result of raising a person above his usual emotional plane; negative pleasure is merely relief from anxiety and pain. Kolb, L.: Pleasure and Deterioration from Narcotic Addiction, Ment. Hyg. **9**: 699 (Oct.) 1925.

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from Demerol is intense, sustained, and you want to keep that feeling all the time."

After his admission to this hospital, he was pleasant and cooperative as long as he was maintained on 100 mg. of meperidine hydrochloride every four hours. He threatened to leave the hospital against advice when the dose was reduced to 75 mg. every four hours. He remained in bed, was depressed and complained of anorexia, insomnia and abdominal pain after a further diminution in the dose to 50 mg. every four hours. This behavior disappeared when the amount of the drug was increased to 100 mg. every four hours but returned when, unknown to the patient, 15 mg. of morphine sulfate every four hours was substituted for the meperidine hydrochloride. A slow reduction withdrawal of the drug was attempted without success, because the patient left the hospital against medical advice when the dose had been reduced to 50 mg. four times a day.

CASE 2.—Patient B, a white woman prisoner aged 44, received opiates for the first time in 1924 while hospitalized for "migraine headaches and sinusitis." She received 60 mg. of codeine sulfate daily for ten days and stated that pleasurable sensations were not associated with the medicament. From 1924 until the present, she has had headaches which were controlled at first by acetylsalicylic acid compounds. After a series of emotional traumas in 1937 her headaches became "unbearable." She then resorted to an occasional oral dose of codeine sulfate, which was prescribed by her physician. She never took more than 60 mg. over a period of a week and experienced only minor relief. She stated that because she was a registered nurse she had access to morphine and administered approximately five injections of this drug to herself over a period of four years. She never injected more than 7 mg. of morphine sulfate at one time. From 1924 until 1946 she had used these medicaments only occasionally, and evidence could not be found in her history of the development of physical dependence, tolerance or habituation to the drug.

In January 1946 she had a headache and took 50 mg. of meperidine hydrochloride hypodermically. This had a twofold effect. It produced the desired analgesia and a sensation of "calmness" which the patient enjoyed. Initially she used 50 mg. of the drug hypodermically once a week. After three weeks she started to increase her doses and to decrease the interval between injections. She did this because she desired to experience the pleasurable sensations, and 50 mg. of the drug no longer controlled the discomfort from her headache. From March 1946 until August 1946, when she was arrested, she was taking between 300 and 400 mg. of meperidine hydrochloride every two or three hours. She obtained it by forging prescriptions and by stealing it from hospital wards and from patients whom she was nursing. Although she knew she would eventually be apprehended, she stated that "the yearning for Demerol surpassed all other considerations."

In discussing the drug's effects she said: "Demerol relieved my nervousness and made me feel normal. It would stimulate me, and I would be able to work without fatigue. I took more and more Demerol in order to experience the wonderful sensations, even more than to relieve my headaches. Although it (the drug) didn't always relieve my headaches, it always gave me extreme pleasure, and I really yearned for it if I couldn't obtain it. Opiates never gave me relief or pleasure. When I can't obtain Demerol, I get irritable, can't sleep and only think about where I can get more."

The patient had not received narcotics for twelve days prior to entering this hospital and did not show evidence of physical dependence after admission. Her history of the period during withdrawal indicated the existence of physical dependence at that time.

CASE 3.—Patient C, a white man volunteer aged 30, was hospitalized for three weeks in October 1943 because of virus pneumonia. He received occasional injections of morphine sulfate for pleuritic pain but did not recall positive pleasure derived from the medicament. After his release from the hospital in November 1943 he received 60 mg. of codeine sulfate daily, which dosage was increased to 240 mg. daily because of persistent pleuritic pain. In December 1943 the dosage of codeine was abruptly stopped and 15 mg. of morphine sulfate was administered hypodermically four times a day for two weeks. At the end of that time the medicament was abruptly changed back to codeine, and he remained on 240 mg. of codeine daily until March 1944. During this four-month period he was under a physician's care, and the history lacked evidence of an abstinence syndrome when codeine was substituted for morphine.

In March 1944 he was given 50 mg. of meperidine hydrochloride hypodermically four times a day "to prevent addiction to opiates." Within two weeks of that time his pleuritic pain disappeared, but he continued to take the drug, which he obtained by devious means, because he liked the sensation it produced. From March 1944 until June 1944 he found that it was necessary to increase his dosage repeatedly in order to produce the desired sense of well-being. He eventually reached a dosage of 500 mg. every four hours. He noticed that he became "nervous" while taking 2,500 mg. a day and therefore used between 1 and 2 Gm. of sodium amytal intramuscularly daily. He was unable to obtain meperidine hydrochloride in June 1944 and "experimented" with the use of morphine sulfate in order to find a "satisfactory substitute." The average dose was about 15 mg. of morphine hypodermically four times a day until August 1944. He stated that although he experienced a "heavy quiet feeling" from morphine, he did not have the intense pleasure associated with meperidine hydrochloride. For eight months, between August 1944 and March 1945, he was able again to obtain the drug and he used it, morphine sulfate and sodium amytal at the same time. He never used more than 60 to 120 mg. of morphine sulfate a day but did use between 2,000 and 3,000 mg. of meperidine hydrochloride a day. In March 1945 he was admitted to this hospital for treatment of addiction and left contrary to medical advice after sixteen days. On departure he relapsed immediately to the use of meperidine hydrochloride and morphine. He was taking approximately 60 mg. of morphine and 4,000 mg. of meperidine hydrochloride daily when he was treated in a private sanatorium in July 1945. He left the sanatorium at the end of two weeks on a daily dosage of 240 mg. of codeine and 200 mg. of meperidine hydrochloride orally. He reverted to the use of the latter drug hypodermically after five weeks and used it alone in preference to morphine.

He was taking 3,000 mg. of meperidine hydrochloride a day hypodermically when readmitted to this hospital in June 1946. He did not receive medication for twelve hours prior to admission and demonstrated objective signs of abstinence when admitted. His ability to tolerate large doses of the drug was demonstrated when 500 mg. was administered every four hours and toxic effects did not develop. Any increase in the dose above 500 mg. was followed by anxiety, insomnia and ataxia. In describing the drug's effects he stated: "It gives me relief from tension, makes me feel normal, makes me feel ambitious, there is no other feeling like it." He noticed a decided loss of sexual drive while using meperidine hydrochloride. He stated that he preferred its effects to those of morphine and when given a choice he would always take meperidine hydrochloride. He did not receive the drug after the fifteenth hospital day and left the hospital against medical advice after thirty days.

COMMENT

Himmelsbach[2] stated that addiction to the opiate drugs embraces three related phenomena: First, tolerance, or the gradual decrease in the effect produced by the repeated administration of a drug; second, physical dependence, which is manifest by the appearance of a characteristic illness if the drug is withheld, and third, habituation, or psychic dependence, which implies an intense desire for the repetition of pleasurable effects associated with the use of a drug.

2. Himmelsbach, C. K.: I. Clinical Studies of Drug Addiction; II. Rossium Treatment of Drug Affliction, Pub. Health Rep., 1937, supp. 125.

Meperidine hydrochloride should be regarded as an addicting drug in the same class as the opiates because all three phenomena have been shown to occur after its use. Andrews [3] demonstrated that tolerance to the drug's elevating action on the pain threshold develops readily. That tolerance to the euphoric effects developed in the cases reported here is indicated by the fact that all 3 patients had to increase their dosage repeatedly in order to reproduce the pleasurable sensations desired. Patient C had undoubtedly developed a high degree of tolerance to the toxic effects of meperidine hydrochloride, as he was able to take as much as 500 mg. hypodermically at a single dose without any clinical evidence of untoward effects. Himmelsbach [4] demonstrated that physical dependence to the drug develops. A definite abstinence syndrome similar to, but less intense than, the morphine abstinence syndrome appeared following abrupt discontinuation of the drug after it had been administered to former morphine addicts over a period of one or two months. Other investigators [5] found evidence of physical dependence in patients receiving the drug therapeutically. Signs of abstinence, which were relieved by its administration, were evident on admission in patient C. Batterman and Himmelsbach [6] reported that habituation occurred after the administration of 75 mg. of meperidine hydrochloride four times a day for three months but did not give details. Strong psychic dependence occurred in the 3 patients whose histories are given here. This was manifest by their statements of the pleasurable sensations produced by the drug and by the energy they expended and the risks they took to obtain more of it in order to reproduce the euphoric effects.

In September 1946, Anslinger,[7] in a letter to the Editor of THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION briefly described 14 cases of addiction to meperidine hydrochloride, 8 of which appeared to be examples of primary drug addiction. Patients A and B had never been addicted to other narcotic drugs and therefore are to be regarded as primary meperidine hydrochloride addicts. Although patient C received codeine and morphine sulfate for six months prior to becoming addicted to meperidine hydrochloride, he probably can be regarded as an example of primary addiction to this drug. His history is particularly significant because it demonstrates a preference for meperidine hydrochloride over morphine.

SUMMARY

Three cases illustrating addiction to meperidine hydrochloride have been reported. Two cases were examples of primary addiction to this drug. The third case demonstrates the occurrence of preference for meperidine hydrochloride over morphine.

CONCLUSION

Meperidine hydrochloride (Demerol hydrochloride) is an addicting drug. The same precautions should be observed in its use as in the use of the opiate drugs.

3. Andrews, H. L.: Development of Tolerance to Demerol, J. Pharmacol. & Exper. Therap. **75**: 388 (Aug.) 1942.
4. Himmelsbach, C. K.: Studies of Addiction Liability of Demerol, J. Pharmacol. & Exper. Therap. **75**: 64 (May) 1942; Further Studies on the Addiction Liability of Demerol, ibid. **79**: 5 (Sept.) 1943.
5. Noth, P. H.; Hecht, H. H., and Yonkman, F. F.: Demerol: A New Synthetic Analgetic, Spasmolytic and Sedative Agent; Clinical Observations, Ann. Int. Med. **21**: 17 (July) 1944.
6. Batterman, R. C., and Himmelsbach, C. K.: Demerol: A New Synthetic Analgesic; Review of Its Present Status and Comparison with Morphine, J. A. M. A. **122**: 222 (May 22) 1943.
7. Anslinger, H. J.: Demerol, Correspondence, J. A. M. A. **132**: 43 (Sept. 7) 1946.

Special Article

HISTORY OF THE AMERICAN MEDICAL ASSOCIATION

MORRIS FISHBEIN, M.D.
Editor, Journal of the American Medical Association and Hygeia, the Health Magazine
Chicago

(Continued from page 988)

(NOTE.—*Following is the eighth chapter of a history of the American Medical Association, in process of development for publication in connection with the celebration of the Centennial of the American Medical Association in Atlantic City in June 1947.*

The general account of the history of the Association will be followed by individual histories of the various councils, bureaus, publications and other activities of the Association. The general account is written by the editor of THE JOURNAL. *Each of the other historical contributions will be by a member of the individual council, bureau or agency responsible and now associated with it or directly related to its work. Included will be photographs, signatures and a brief biography of each of the hundred presidents of the American Medical Association. This feature has been prepared by Dr. Walter L. Bierring.*

It will be impossible to publish all of the material in THE JOURNAL. *The complete work will be published in book form. It is hoped to have it available by the time of the annual session.*—ED.)

CHAPTER 8. THE CIVIL WAR LOOMS

1858

WASHINGTON, D. C.

The Code of Ethics was not merely window dressing; conspicuous in the session of 1858 was an apology by Dr. David M. Reese for having put on the staff of the Blockley Hospital of Philadelphia a physician who had been expelled from the American Medical Association for a violation of the Code of Ethics. The apology of Dr. Reese stirred a tempest; by the third day of the session the delegates were convened as a committee of the whole on a motion to reconsider, and Dr. Reese amended his apology by adding the words that he "regretted the action taken."

Throughout the nation there was great turmoil, for these were the years before the Civil War; but there is nothing in the discussions of the American Medical Association at that time indicating any thought that war was impending. The basic questions leading to the war were not discussed, nor is there any action indicating movement toward medical preparedness.

Most of the discussions were concerned with the reports of the committees on epidemics and on literature. American physicians had begun to take pride in their own publications. Again Austin Flint won the essay contest with a paper on "The Clinical Study of the Heart Sounds in Health and Disease."

The report on medical education was brief; the evidence indicated that standards were slowly improving. The number of scientific contributions was small.

Appended to the permanent transactions of the Association were the complete principles of Ethics, a practice that has been followed since that time.

1859

LOUISVILLE, KY.

In welcoming the members to Louisville in the following year the community took pride in informing the members of the American Medical Association of its

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two medical libraries containing, respectively, 4,000 and 8,000 volumes.

For the first time at the 1859 convention definite action was taken urging the legislatures of the individual states to pass laws that would control the practice of illegal abortion.

Only six essays had been submitted to the essay committee.

By this time, however, the Association had so modified its original constitution that it became necessary to issue a revision of the so-called "Plan of Organization," so that all the members could understand the various functions and technics concerned in the various committees, boards and other agencies.

Still the transactions say nothing whatever indicating that the nation was trembling on the verge of a great war.

1860

NEW HAVEN, CONN.

By the 1860 session Dr. N. S. Davis thought that a little more order ought to be introduced into the manner of the meeting. A resolution was offered that the morning meetings be devoted to the work of the Association and the afternoon sessions to the hearing of papers and discussions on scientific subjects.

The address of the President, Dr. Henry Miller, brought up openly the question of illegal abortion. On behalf of the American Medical Association, he urged action by legislatures in every state against this practice. Dr. Miller reviewed the growth of the Association and asked for renewed effort toward raising the standards of medical education.

1863

CHICAGO

The thirteenth annual meeting of the American Medical Association had been held in New Haven, Conn., in June of 1860. The next session—the fourteenth—convened in Chicago on June 2, 1863. Early in 1861 the usual notices for the regular meeting were issued. The preliminary arrangements were made. Then, according to Dr. N. S. Davis, "the sectional animosity and wickedness which had been threatening the peace of our country for several years culminated in an open, unjustifiable and monstrous rebellion." Letters were received from most of the active members of the Association asking postponement of the annual meeting. Although there was nothing in the constitution and by-laws to authorize either the officers or any one else to postpone a regular meeting, the committee finally decided to postpone until June 1862. Just about that time the battles of Belmont, Fort Donelson and Shiloh occurred; most of the members of the medical profession were needed in the prosecution of the war.

The meeting was postponed until June 1863; in February Chicago was selected as the place of meeting. Another difficulty now arose: a decision by the convention of railroad officers that there would be no further commutation of railroad fares. However, a special meeting of the railroad executives permitted them to make a commutation rate for attendance on the National Canal Convention, which was held in Chicago at the same time. The delegates to the American Medical Association were invited to sit in the National Canal Convention, where they were recorded as delegates and thereby got free tickets home.

A considerable number of delegates assembled in Bryan Hall; some of the meetings were held in the Methodist Church Block.

Apparently the Surgeon General of the Army had issued an order prohibiting the use of calomel and antimony. The American Medical Association appointed a committee to find out why. Another committee was established to see whether vaccination against smallpox should not be compulsory throughout the United States. Majority and minority reports were received on the use of calomel and antimony in the Army, and the whole subject received a most spirited discussion. A statement from the Surgeon General indicated that the use of both calomel and tartar emetic had been abused; he believed that more harm resulted from the use of both these agents than benefit from their proper administration. Many of the committee thought that this charge by the Surgeon General was entirely unwarranted. They felt that he was giving impressions and that he did not have good statistical evidence to support his opinion. Then, getting even stronger, they said that he had "committed a most grievous offense against the dignity, usefulness and humanity of our profession; that he has heaped unmerited *insult* on an intelligent, scientific and humane corps of army surgeons; that he has injured, in a most serious manner, the regular profession. We regard the order as an unwarrantable assumption of authority and a reckless attempt to cut the Gordian knot of intricate pathology by the exercise of official power." They considered his circular unwise; the withholding of ordinary medicines implied a want of confidence in the skill of physicians; they recommended that he either withdraw the circular or rewrite it.

Another resolution said that the railroads were fast becoming the great medium of land travel and that they were having many serious accidents without good medical provisions to meet them.

A long resolution called attention to the fact that the doctors in the Army were not given adequate rank and demanded that they be placed in a rank in all respects equal to and on the same footing with others officers in the service. This insufficient recognition of medical services by the line officers and the statesmen is a perennial source of dissatisfaction. When the wars end, the civilian doctors receive high praise. But proper status has never been accorded either them or doctors in the regular military services.

At this convention another fundamental action was recognition of ophthalmology as a distinct specialty in the field of medicine. Medical schools were encouraged to establish chairs in this field.

1864

NEW YORK CITY

When the Association met in New York in 1864 Dr. Nathan Smith Davis of Illinois, founder of the American Medical Association, received a reward by his election to the presidency. Apparently this nomination was not satisfactory to all; a resolution was offered to send it back to the nominating committee with the request that the committee nominate at least two persons for the presidency, to be elected by ballot. This resolution was lost and Dr. Davis was elected.

Only one resolution on the war seems to have been offered at this session, a memorial to the President of the United States respecting the necessity for the organization of an ambulance system for the U. S. Army.

More than thirty-five committees brought reports on all sorts of subjects, both scientific and political, and there were reports from the usual standing committees.

Again as the session ended there was a resolution from New York urging the President of the United States to take such action as shall cause "all medicines and medical and surgical instruments and appliances to be excluded from the list of articles called 'contraband of war,' and that such articles in any quantity may be purchased by any person in any state of the Union, and may be conveyed beyond our lines under a flag of truce" to the people in the Southern blockaded cities. Furthermore, it was resolved that "every member be requested to use all of the influence in his power in stripping this fratricidal war of some of its unnecessary horrors and thereby to inaugurate the reestablishment of more kindly feelings, and to smooth away some of the obstructions to the reconciliation of our misguided brethren." Of course there were no delegates from south of the Mason and Dixon Line at the convention. However, one physician moved promptly to lay this highly idealistic resolution on the table. Another physician moved to add the word "indefinitely." That was passed.

By this time, moreover, there had begun to be some dissatisfaction with the nominating committee which offered just one nomination for president. A resolution was offered to amend the by-laws providing for nominations from the floor. The question was raised of the right of Dr. William Thomas Green Morton to receive any vast sum for his discovery of anesthesia or for a patent on anesthesia, and the delegates voted unanimously to oppose such actions.

In the *Medical and Surgical Reporter*, a weekly medical journal published in Philadelphia, the issue for Jan. 14, 1865 made a critical review of the progress of the American Medical Association. It suggested omission of proofreading by authors to hasten publication of the Transactions. The Philadelphia editor pointed out the undemocratic character of the technic of choosing delegates. A large county medical society near the place of the meeting could dominate the session. He wanted to do away with the nominating committee. And, he ended, "It is of great importance that the machinery of the Association be made as perfect as possible, for we believe that, rightly managed, it can be made to exert very great influence for good on the profession of this country and of the world."

(To be continued)

Diagnostic Roentgenology.—Five epochal contributions to medicine, spaced over two centuries of time, represent the beginning of physical diagnosis as we know it today. In 1628 Harvey first described the circulation of the blood. Van Leeuwenhoek introduced microscopy in 1670. In 1761 Auenbrugger fathered percussion, and the stethoscope was placed in the hands of physicians by Laënnec in 1819. The ophthalmoscope, first of a long succession of instruments for direct visual diagnosis, was produced in 1851 by Helmholtz. In contrast to this slow rate of progress, as judged by the tempo of our recent medical developments, the discovery of x-rays in the early winter of 1895 gave birth to a unique system of physical diagnosis which promised to carry "inspection" far beneath mere surface markings and threatened to challenge the supremacy of percussion and auscultation in the matter of determining the compactness of deeply situated tissues and organs. Within three decades, diagnostic roentgenology had become established as a vigorous and well respected medical specialty. Thirty-nine years after Roentgen's discovery, American physicians who were especially trained in the new diagnostic method were being certified by a specialty board in radiology.—Hodges, Fred Jenner: Medical Implications of Atomic Energy, *J. Michigan State M. Soc.*, October 1946.

Clinical Notes, Suggestions and New Instruments

GUILLAIN-BARRÉ SYNDROME TREATED WITH NEOSTIGMINE

CHARLES E. TEST, M.D.
Indianapolis

In May 1946 Shaffer [1] reported in THE JOURNAL for the first time on the use of neostigmine in the treatment of the Guillain-Barré syndrome (virus encephalomyelitis). Since that time, further reports have not been forthcoming, and it therefore seemed worthwhile to present additional information on the subject.

REPORT OF CASE

Mrs. M. B., a white woman aged 22, was admitted to the hospital on May 31, 1946 complaining chiefly of headache, stiffness of the neck and a generalized feeling of numbness. She had been in good general health until about two weeks prior to admission, when a "head cold" developed which was characterized by nasal congestion, sneezing and frontal headache of moderate severity, without fever or other constitutional symptoms. For a week she continued her usual daily activities, but on May 22 she felt generally ill and weak. She went to bed at this time and began to experience continuous severe pain in the upper part of the back and neck, together with occipital headache. On the following day she noticed numbness of the second, third and fourth toes of the right foot, and by May 29 her entire body felt numb. On this day she also became nauseated and vomited on two occasions. The vomitus was dark green in color. She had urinary incontinence at this time. According to the patient there had been no elevation of temperature throughout any part of her illness.

Data on Cerebrospinal Fluid

	5/31/46 (On Admission)	6/3/46	8/11/46
White cell count (per cu. mm.)	0	10	2
Red cell count (per cu. mm.)	0	0	0
Pandy test	..	4+	4+
Sugar (mg./100 cc.)	57	73	76
Total protein (mg./100 cc.)	90	312	408
Wassermann	Negative	..	Negative
Gold curve	4443310000	..	5555544433
Culture	Negative	Negative	Negative
Initial pressure	60 mm.	100 mm.	..

The past history was essentially noncontributory. A tonsillectomy had been performed in 1940 without complications. In January 1946 she gave birth to a premature male infant. Labor and the postpartum course were apparently normal.

On admission the oral temperature was 99.2 F., the pulse rate was 96, the respiratory rate 20 and the blood pressure 120 systolic and 80 diastolic. The patient did not appear acutely ill. There was pain on flexion of the neck, but true rigidity was absent. The pupils reacted normally, and there was no papilledema. The pharynx was not injected, and there was no cervical lymphadenitis. Examination of the heart and lungs revealed essentially normal conditions. The abdomen was generally tender on examination, and the abdominal reflexes could not be elicited. The biceps and triceps reflexes of the arm were normal. The knee jerks were elicited only after reenforcement; the ankle jerks were normal. The great toe reflex was not present, and other pathologic reflexes could not be elicited. There was no definite sensory loss on neurologic examination. Function of the cranial nerves appeared to be intact.

The laboratory data on admission May 31, 1946 were as follows: Examination of the blood revealed a hemoglobin content of 14.0 Gm. per hundred cubic centimeters and a white blood cell count of 6,350, with a differential count of band cells 5 per cent, adult polymorphonuclears 61 per cent, lymphocytes

From the Department of Medicine, Indiana University School of Medicine.

1. Shaffer, J. O.: The Use of Neostigmine in the Treatment of the Guillain-Barré Syndrome, J. A. M. A. **131**: 285 (May 25) 1946.

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30 per cent, large monocytes 3 per cent and eosinophils 1 per cent.

Urinalysis of a voided specimen showed the specific gravity to be 1.030, with the reaction neutral, albumin present in a faint trace, sugar none, casts none, pus cells 2 to 6 and red cells none. The data on the cerebrospinal fluid is given in the accompanying table.

On June 1, 1946, twenty-four hours after admission, it was noted that palsy had developed on the left side of the face. On June 3, 1946 neurologic examination revealed the persistence of the left facial paralysis and diminution of all deep tendon reflexes but failed to reveal other abnormalities, although the patient still complained of numbness over the body and pain in the back of the neck and in the occiput. During the succeeding weeks she complained a great deal of headache and generalized aching pains. At times pain and spasticity of the arms were so severe that she was unable to feed herself. She was constipated and enemas were required. However, the facial paralysis improved decidedly. The results of blood counts and urinalyses remained within normal limits.

By July 14, 1946 objective evidence of neurologic disturbance in the form of reflex changes or gross paralysis was no longer present. However, the patient had severe pain with tenderness, muscle spasm and weakness of both legs and with less severe involvement of both arms. She was irritable, easily upset and in need of frequent anodynes and sedatives. Movement of the legs was so painful that any attempt to walk was out of the question.

On July 15 the patient was given injections of neostigmine methylsulfate in 1:2,000 solution, 1 cc. three times a day subcutaneously. Within four hours after the initial dose she was able to sit in a chair and stated that she had less pain than at any time since entering the hospital. On July 17 the dose of neostigmine methylsulfate was increased to 2 cc. injected three times a day. Atropine sulfate 1/150 grain (0.0004 Gm.) was given hypodermically with each dose to counteract the undesirable side effects of the neostigmine, as recommended by Shaffer. Three days after the initiation of treatment with the drug she was able to walk with assistance, and by July 22 she was able to walk alone from bed to chair in her room. On July 26 the patient was discharged from the hospital. At that time she was easily able to walk alone, with a normal gait.

It is felt that in this instance the use of neostigmine methylsulfate contributed greatly to the rapidity of the patient's recovery and materially shortened her stay in the hospital.

1040 West Michigan Street.

Council on Physical Medicine

The Council on Physical Medicine has authorized publication of the following report. HOWARD A. CARTER, *Secretary.*

OTARION A-3 HEARING AID ACCEPTABLE

Manufacturer: Otarion Hearing Aid Company, 448 North Wells Street, Chicago.

This instrument is of the vacuum tube type. The microphone and amplifier unit is of molded plastic. It measures 5/8 by 2½ by 3½ inches (1.6 by 6.4 by 8.9 cm.) and weighs 3.6 ounces (103 Gm.). In the tests it was energized with a 1.5 volt A battery and 45 volt B battery. The unit submitted had a single combined volume control and on and off switch.

Batteries: The current drain of the A battery (1.5 volts) was 70 milliamperes and of the B battery (45 volts) 1.2 milliamperes.

Acoustical Gain: Measurements of the gain in decibels in the pressure level set up in a 2 cc. coupler over that at the microphone of the hearing aid showed the following results: The gains are for an input sound pressure level of 50 decibels above 0.0002 dyne per square centimeter.

Frequency	256	512	1024	1800	2048	3100	3500	4096 cycles/sec.
Volume control								
½ On.....	21	29	35	64	39	43	36	33 decibels
Full On.....	34	42	50	45	53	53	49	45 decibels

Measurements showed that the instrument produced sound pressure levels reasonably free of distortion, ranging from 115 to 135 decibels above 0.0002 dyne per square centimeter over the frequency range from 256 to 4,096 cycles per second. The measurements made are in fair agreement with the data submitted by the manufacturers.

Articulation: The usual articulation and intelligibility tests were made with a hard of hearing subject, with the following results: Syllable articulation 96 per cent, sentence intelligibility 98 per cent. The whispered voice was heard and understood at a distance of 5 feet in a quiet place with the volume control set at approximately one third of full volume.

The instrument is well made throughout and is fairly free of internal noise.

The Council on Physical Medicine voted to accept the Otarion A-3 Hearing Aid for inclusion in its list of accepted devices.

Council on Pharmacy and Chemistry

NEW AND NONOFFICIAL REMEDIES

The following additional articles have been accepted as conforming to the rules of the Council on Pharmacy and Chemistry of the American Medical Association for admission to New and Nonofficial Remedies. A copy of the rules on which the Council bases its action will be sent on application.

AUSTIN SMITH, M.D., *Secretary.*

PENICILLIN (See New and Nonofficial Remedies, 1946, p. 212).

The following dosage forms have been accepted:

ABBOTT LABORATORIES, NORTH CHICAGO, ILL.

Penicillin Sodium: 500,000 units.

LAKESIDE LABORATORIES, INC., MILWAUKEE

Penicillin Sodium: 20 cc. vials containing 200,000 and 500,000 units.

Penicillin Calcium: 20 cc. vials containing 200,000 units.

THE WM. S. MERRELL COMPANY, CINCINNATI

Penicillin Sodium: 500,000 units.

CHAS. PFIZER & CO., BROOKLYN

Penicillin Calcium: Bulk. Marketed in bottles containing approximately one billion units each.

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THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

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SATURDAY, DECEMBER 28, 1946

CHOLERA

Mortality rates for cholera as recorded in various epidemics in the past have reached 50 to 70 per cent. Experiences with cholera in World War II demonstrate that it may be robbed of much of its terror by proper treatment. Reimann [1] believes that, if all mild, unrecognized cases of cholera could be included in the statistics, the mortality rate would be less than 50 per cent. When promptly and properly treated the disease is short and its mortality low. In a carefully controlled series of 140 cases of epidemic Asiatic cholera treated in a hospital at Chungking, Reimann reports a mortality rate of only 5 per cent and the average duration of attack four days. The low mortality rate he ascribes to prompt, vigorous, controlled rehydration and the restoration of mineral metabolites. Each patient on admission was given an intravenous or intraosseous infusion of 1,000 to 2,000 cc. of warmed isotonic solution of sodium chloride. The amount was determined by the size of the patient and the degree of dehydration as measured by the specific gravity of the blood. About 300 cc. of a 2 per cent sodium bicarbonate solution was added to each injection to combat acidosis when collapse was present or threatened. The patient was also given 50 cc. or more of 1 per cent solution of sodium bicarbonate to drink every fifteen minutes during the acute stage. Patients were urged to drink water or tea and were given liquid, then solid food as soon as they desired. Amazing improvement usually came during or after rehydration, with return to consciousness, with recovery from collapse, hypotension, hypothermia, purging, vomiting and cyanosis, with cessation of cramps, with an increase of urine and with filling out of the shrunken skin. The average duration of the disease in 56 patients treated with rehydration and remineralization alone was 4.6 days; in 30 with sulfaguanidine, 3.8 days, and in 31 with sulfadiazine, 3 days. In 8 patients selected for the severity of their attack and treated on the first day of the disease with streptomycin, the average duration was also 3 days.

1. Reimann, H. A.; Chang, G. C. T.; Chu, Liang-Wei; Liu, P. Y., and Ying Ou: Asiatic Cholera, Am. J. Trop. Med. **26**: 631 (Sept.) 1946.

Reimann believes that the simple administration of salty water reduces the duration of the disease to a few days and the mortality rate to 5 per cent, and therefore there is hardly any need for specific therapy unless it can be shown to abolish the carrier state sooner. Neither the sulfonamides nor streptomycin did. The duration of the presence of viable vibrios during convalescence in the stools of patients not treated with drugs, in patients treated with sulfonamides and in those treated with streptomycin was about the same. Other than a prompt reduction in the number of vibrios and slight shortening of the attacks, Reimann did not find any evidence that streptomycin given orally or parenterally influences the course of the disease.

Reimann's report contrasts strikingly with that of De Wardener [2] on a cholera epidemic among prisoners of war in Siam. The case mortality among the soldier prisoners of war under unfavorable conditions and without treatment averaged from 50 to 60 per cent. Among the 250 sick Dutch troops in the same camp there was only 1 case of cholera. Though they were subject to dysentery and deficiencies to the same extent as the British, the incidence of cholera among the Dutch troops was negligible. The Dutch doctors ascribed this immunity to the yearly cholera inoculations given to all Dutch troops in Java.

Epidemiology Unit No. 50 [3] reports a study of cholera in Calcutta. Some 400 patients were divided into four groups, group A being treated with sulfaguanidine, group B kept as a control, group C treated with sulfadiazine, group D treated with penicillin and group E treated with sulfadiazine and penicillin combined. Probably the most striking effects were due not to the chemotherapy but to plasma transfusions. Of 35 severely ill patients treated with plasma plus chemotherapy, not 1 died. Of 19 similar patients treated with chemotherapy alone, 3 died, and of 24 control patients, 23 died. This investigation likewise supports the statement that chemotherapy with supportive treatment, that is, utilizing rehydration, will effectively lower the expected death rate in cholera. The addition of adequate amounts of blood plasma to the therapy of cholera will definitely improve the chance of recovery.

DELAYED PRIMARY MALARIA

THE JOURNAL has directed attention in previous editorials to the problem of malaria in military and civilian personnel who have been in endemic areas during the war. Falciparum malaria, with few exceptions, is definitely cured during the acute attack and does not tend to recur. Vivax malaria, by far the most widespread type of malaria among returning soldiers, appears to be well controlled by quinacrine or quinine during the acute attack but recurs in a large percentage of cases. A delayed primary attack may occur after

2. De Wardener, H. E.: Cholera Epidemic Among Prisoners of War in Siam, Lancet **1**: 637 (May 4) 1946.

3. Epidemiology Unit No. 50: Report on Cholera Studies in Calcutta, U. S. Nav. M. Bull. **45**: 1049 (Dec.) 1945.

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discontinuance of suppression as the first clinical manifestation of malaria.

Most delayed primary attacks are clinically indistinguishable from later relapses of vivax malaria. However, occasionally a difficult diagnostic problem is presented because of (*a*) the absence of a previous history of malaria, (*b*) greater incidence of negative smears or of extremely low parasite counts at the onset of the attack, (*c*) absence of characteristic physical findings and (*d*) an unusual onset in some cases, for example, irregular fever without chills and with negative smears or severe abdominal pain, tenderness, nausea and vomiting before the occurrence of the paroxysm.

Four army investigators [1] have recently reported studies of 169 cases of such delayed primary attacks and 486 cases of later relapses carefully observed in the tropical disease section of Moore General Hospital. During the acute attack various antimalarial drugs were used. After subsidence of the acute attack observations were continued until relapse or for one hundred and twenty days. During this time antimalarial drugs were not given and smears were examined twice weekly. The mean time interval in 101 patients of this series was forty-one days between the discontinuance of suppressive medication and the initial attack. The range was from nineteen to sixty-three days, a standard deviation of 22.2. In other words, some two thirds of delayed primary attacks will occur between approximately the third and the ninth week after the end of suppression. Contributing to these variations were differences in suppressive regimens used in endemic areas and variations in the time required for quinacrine plasma concentrations to drop to minimal effective levels after cessation of medication. In addition, during suppressive treatment recurrences of malarial activity may occur without clinical manifestations of the disease as long as the plasma concentration of quinacrine remains at an effective level. With discontinuance of suppression and fall of plasma quinacrine concentration the time of occurrence of the clinical attack will then depend on the periodicity of the infection in the individual and on the time of the last preceding episode of suppressed malarial activity.

The authors also found that 54 per cent of the delayed primary cases gave parasite counts less than 1,000 per cubic millimeter, whereas this was true in only 31 per cent of later relapses. Despite these lower initial parasite counts, the rate of parasite clearance under treatment was somewhat slower in the delayed primary attack than in the later relapse, and fever was less readily controlled. These findings suggest a diminished sensitivity to the malaria parasite and the development of some immunity in the course of recurrent vivax malaria.

1. London, Irving M., and others: The Delayed Primary Attack of Vivax Malaria, New England J. Med. **235:** 406 (Sept. 19) 1946.

CANCER MORTALITY IN SWITZERLAND

Cancer mortality for Zurich has increased since 1900, owing, as elsewhere, to prolongation of the life span of the general population and not to an increased incidence of cancer among people of the same age. This statement of Schinz and his associates [1] is supported by evidence that the total cancer mortality for both sexes is actually lower when calculations are corrected according to prolongation of the life span. The probability that death from cancer will occur before the sixtieth year of age has decreased for both sexes. Probability of death from cancer occurring between the ages of 60 and 75 years has diminished for women, but a similar change for men could not be ascertained. Death from cancer occurring after the age of 75 has increased for both sexes. When compared to other causes of death, figures for cancer have increased for all age groups and for both sexes.

Cancer of the stomach occupies first place in order of frequency in men, with cancer of the esophagus second. In women cancer of the stomach is first in order of frequency, with cancer of the breast second since 1926 and cancer of the uterus third. Prior to 1926 cancer of the uterus occupied second place and cancer of the breast third. Probability of death from cancer mounts with increasing age for all the important cancer localizations except for cancer of the lung. Men with a tendency to pulmonary cancer are eliminated through death before reaching the age of 75 or more years. Predisposition to cancer varies considerably for different age periods. The relationship between cancer and age is most definite in cancer of the prostate, while pulmonary cancer shows the least dependence on age. Cancers of the esophagus, the stomach, the colon and the rectum occupy a middle position between the two extremes. In women a definite age predisposition is noted in cancer of the stomach, the colon and the rectum and the least definite age predisposition in cancer of the breast, the uterus and the ovaries. Pulmonary cancer in men and cancers of the breast, the uterus and the ovaries in women are regarded as "early cancers"; cancer of the digestive tract, and particularly cancer of the prostate, are considered as "late cancers." The authors found a notable decrease since the turn of the century in the incidence of cancer of the stomach in men aged 30 to 74, a rather definite increase in pulmonary cancer in men from 45 to 74, a decrease in the incidence of cancer of the esophagus in men from 45 to 74 and an increase in men past 75. A definite decrease was noted for cancer of the stomach for women aged 30 to 74, an increase in breast cancer particularly for women from 45 to 59 and a decrease of uterine

1. Schinz, H. R.; Rosin, S., and Senti, A.: Entwicklung und Stand der Karzinomsterblichkeit in Zürich, in der Schweiz und im internationalen Vergleich, Schweiz. med. Wchnschr. **76:** 743 (Aug. 17) 1946; II. Karzinomsterblichkeit in der Schweiz, ibid. **76:** 779 (Aug. 24) 1946.

cancer for all age groups. The general cancer mortality of Switzerland as a whole is analogous to that of the city of Zurich.

Vital statistics in Switzerland are carefully kept so as to include as far as possible all fatalities caused by cancer. The same cannot be said for some of the other European countries, where many cancer deaths are probably listed as due to old age. To compensate for this defect the Swiss experts adopted the rule of adding one fifth to the cancer mortality of those countries. Cancer statistics for southern and southwestern Europe —for the countries south of the Alps (Portugal, Spain, France, Italy and Greece)—are among the lowest. It would be erroneous to assume that treatment of cancer is more effective south of the Alps than north of the Alps. The authors suggest that a comparison of the incidence of cancer among the colonial populations of European descent might show whether this difference depends on geographic factors or on genetic differences of various nations.

Current Comment

THE COUGH SYRUP

Boyd [1] has summarized investigations extending over the past six years on the pharmacology and therapeutic rationale of cough syrups. This form of medication is almost as old as medicine itself, and the use of syrups to control cough has been purely empirical. On the assumption that the beneficial effects of this form of medication result from an expectorant action, Boyd and his colleagues have investigated the effects of various syrupy mixtures on animals and measured the amount of fluid produced in the respiratory tract following oral administration of these remedies. Simple syrup increases the output of respiratory tract fluid and exerts a demulcent effect on the mucosa of the pharynx. This action is short and is not observed if the syrup is introduced directly into the stomach. So-called expectorant drugs such as acid ammonium salts, thymol, guaiacols, creosote, paregoric, ipecac and iodides do not exert their effects until absorbed from the intestinal tract. Certain of the syrupy vehicles, including wild cherry, squill, licorice and ginger, act like simple syrup in that no expectorant action is seen when administered by stomach tube. Syrup of tolu is an exception, since it appears to produce an increased respiratory tract secretion even when administered by gastric tube. Boyd concludes that the time honored cough syrups do, in general, exert a significant expectorant action and that the syrup per se augments this action for a brief period immediately after oral administration. He leaves unanswered the question of whether converting a "dry" cough to a so-called productive cough is in itself a desirable or rational procedure.

1. Boyd, Eldon M.: The Cough Syrup, Brit. M. J. **2**: 735 (Nov. 16) 1946.

PARKINSONIAN SYNDROME

Recently an examination of the clinical features of 320 cases of Parkinson's syndrome recorded during the present century has been made in an attempt to evaluate the changes that have occurred in etiology and also the modifications in clinical form. The majority of cases of parkinsonism observed from 1900 to 1929, according to Dimsdale,[1] were cases of true paralysis agitans. The symptoms developed in the second half of life, with a modal age of onset of between 51 and 60 years. In more than half of these cases the duration of symptoms had not exceeded two years. The principal symptom and objective sign was tremor involving the right side of the body. Abnormal mental states were rare and were restricted to the older patients. Ocular movements and pupillary reactions were usually normal, and excessive salivation was unusual. Of the 100 cases observed during the 1900-1919 period only 3 juvenile and 2 senile cases were recorded. In the next ten years, from 1920 to 1930, 100 additional cases were studied. Thirty-four resembled the previous group in most clinical features. In 54 of this group the syndrome resulted from an attack of encephalitis lethargica, the sequelae of which were usually immediate. Mental symptoms and disorders of sleep were common. Shakiness was the most general symptom, but rigidity appeared more prominent on objective examination, though right-sided predominance was general. In this group the incidence of excessive salivation was high, and ocular signs consisting of abnormalities of external ocular movement and pupils complicated the parkinsonism. Failure of the pupil to contract on accommodation was common. Eleven of the 100 cases in the 1920-1930 group were classified as indeterminate parkinsonism, which resembled that due to encephalitis in clinical form but differed in that a history of encephalitis was absent. One case of parkinsonism and neurosyphilis was included. From 1931 to 1942, 120 cases were studied. Fifty-two were in the group of typical paralysis agitans and conformed in age, distribution, duration of symptoms and objective signs to the classic type. Of the 24 cases of post-encephalitic parkinsonism in this series there was a characteristic long latent period and prolonged duration of symptoms. There were 42 cases of indeterminate parkinsonism. These showed an age distribution suggestive of an etiologic factor incident in young people in the years corresponding to the epidemic of encephalitis lethargica. Rigidity was prominent, and there appeared to be a definite left-sidedness of signs, which was difficult to explain. The clinical significance of the apparently changing picture of Parkinson's syndrome is uncertain. It is well to remember that the cases on which Dimsdale's paper is based come from only three sources in England, namely the University College Hospital, the Maida Vale Hospital for Nervous Diseases and the private records of Dr. Russell Brain. Nevertheless, studies such as this on the changing clinical picture of disease may prove extremely fruitful.

1. Dimsdale, Helen: Changes in the Parkinsonian Syndrome in the Twentieth Century, Quart. J. Med. **15**: 155 (July) 1946.

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ORGANIZATION SECTION

PROCEEDINGS OF THE CHICAGO SESSION

MINUTES OF THE SUPPLEMENTAL SESSION OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION, HELD IN CHICAGO, DECEMBER 9-11, 1946

(Continued from page 1015)

HOUSE OF DELEGATES

First Meeting—Monday Morning, December 9 Continued

Report of Special Committee on Executive Session for Consideration of Rich Report

Dr. William Bates, Chairman, presented the following report, which was adopted section by section on motion of Dr. Bates, duly seconded and carried:

The members of the House of Delegates and the officers are all familiar with the presentation of a part of the Rich Report at the San Francisco Session last July.

Since that time this committee was appointed and met with the Executive Committee of the Board of Trustees in September in Chicago. Each member received a copy of the report and it was gone over line by line. In addition, we received reports from various department and bureau heads concerning that part of the Rich Report which referred to their respective departments or bureaus.

After that, this forty-five page report was broken up into six comparatively equal parts for study by the Committee members. On last Saturday, Dec. 7, 1946, we met to correlate the various studies. On Sunday, Dec. 8, 1946, with a preliminary draft of our report practically completed, we met with the Board of Trustees for further consideration.

Today we come before you prepared to present the results of our studies, but in view of the fact that most of you have not seen the original and complete Rich Report, your Committee recommends:

1. That each member of the House of Delegates be given a copy of the Rich Report, also a copy of this committee's report, on a special roll call at the end of this morning's session.

2. That the first order of business on Tuesday be reserved for the report of this special committee of the House of Delegates, and

3. That it be considered by this House at that time in executive session limited to members of the House of Delegates and officers of the Association, acting as a Committee of the Whole.

4. That each delegate be requested to bring his copy of the Rich Report so that a full, free and complete discussion of this subject may be had.

Copies of the so-called Rich Report and of the report of the special committee referred to in the recommendations were then distributed to each delegate called by roll, and consideration of the reports was ordered for the next day in executive session, the House to sit as a Committee of the Whole.

Report of Committee on Military Rank

Dr. B. R. Kirklin, Chairman, presented the following report, which was referred to the Reference Committee on Miscellaneous Business:

Your committee, which was authorized by the House of Delegates at its annual meeting in San Francisco last July, has inquired into the general situation of military rank accorded to members of the Medical Corps of the United States Army and advises that there is now being formulated a plan for more rapid promotions and higher rank, but it has not yet matured to the point where it seemed wise for us to seek an appointment with the Secretary of War. Furthermore, the Secretary of War has appointed an advisory committee composed of outstanding medical men, all of whom served in World War II. This committee is now in the process of formulating recommendations concerning the Medical Department of the Army.

Among its recommendations will undoubtedly be included that of increased military rank. It is therefore thought advisable for this committee to time our conference with the Secretary of War in such a way that it can do the most good.

Your committee, therefore, requests its continuance with instructions to report back to this body at its annual session in Atlantic City next June.

Report of Committee on Rural Medical Service

Dr. F. S. Crockett, Chairman, presented the following report, which was referred to the Reference Committee on Medical Service:

The second annual Rural Health Conference will be held February 7 and 8, 1947. The first conference, held on March 30, 1946, was reported at the San Francisco meeting. This first conference was largely exploratory affording opportunity for a revelation of mutual interests and the development of a more understanding appreciation of many factors affecting the producer and consumer of medical service in rural areas.

A two day meeting is planned with all organized farm groups invited to participate in discussions and formulation of conclusions in six important parts of the rural health problem. Discussion groups will be organized about the following subjects: (1) Bringing and holding well qualified physicians in rural communities. (2) Hospital facilities and health centers. (3) Voluntary medical prepayment plans. (4) Nursing needs of rural communities. (5) Health councils as agency for promoting rural health. (6) Medical care for lower income groups. The findings and conclusions of these committees will be presented to the full assembly for discussion and action during the morning of the second day. The meeting will terminate with a luncheon addressed by Hon. Melville Broughton, former Governor of North Carolina. After the formal program is closed, the committeemen from all the states will have a closed session for a discussion of problems of mutual interest.

In August the President signed the Hill-Burton Bill for federal assistance in construction of hospitals and other related facilities. Special provision in the bill requires that priority be given to rural areas in greatest need. Assistance consists of grants of one third the cost of approved projects. Since the greatest need exists usually in areas with the least economic resources it is evident that each state will need to develop plans to meet this situation. The bill will assist in building two types of health facilities—hospitals in whole or in part for governmental units, church or other nonprofit corporations, or facilities less than hospitals, often referred to as health or diagnostic centers. The health center must include housing for the local public health service provided by the particular state laws. In

addition to this there may be diagnostic laboratory and x-ray, doctors and dentists offices, and beds for emergency cases and normal obstetrics, any one or any combination to suit local needs.

Farmers interested in improving their community want primarily a physician. It is doubtful if much enthusiasm could be stimulated in a public health facility if it did not also do something to bring and hold a physician.

It was the privilege of the chairman of the Committee on Rural Medical Service to act as a member of two of the advisory committees invited to assist the Surgeon General of the Public Health Service and his executive council in the formulation of policy for the administration of the Hill-Burton bill. Every effort is being made to fulfil the intent of the Congress in extending the benefits of this legislation.

The Council on Medical Service has expended a great deal of time and attention on the prepaid medical insurance plans now developing in nearly all the states. Convenience and economy cause first efforts to be directed to employees of industry and it is only after some financial stability and executive "know how" has been acquired that the plans can be offered to rural groups or rural communities. Some few state plans are now exploring this opportunity for service. Blue Cross has enrolled over 1,500,000 rural people and is finding increasing acceptance of its plan. It seems quite evident that prepaid medical and hospital plans will play an important part in making available and more accessible to farmers medical and surgical care in catastrophic illness.

The Bureau of Information has sent a questionnaire to all county medical societies to learn the present need for physicians, especially in rural areas. Many returning medical officers have located in the villages.

The development of cooperative associations and other consumer controlled groups for provision of medical care has received considerable attention. There are some 89 cooperatives in 31 states now operating. This is an interesting experiment in the rural effort to do something constructive from the point of view of the consumer. The medical profession should be concerned in all these plans with the view that a high level of medical care be supplied. Since these groups expect to employ physicians, some minimum standard, or the basic principles involved in such contracts, should be adopted by this House of Delegates for the guidance of physicians entering such employment and for the consideration of employing groups interested in establishing a high standard of medical care.

The Committee on Rural Medical Service is very fortunate in that its members live in and represent the principle rural areas of the nation. This selection has been completed recently by the addition of two new members. It is with pleasure and assurance that this committee welcomes Dr. F. A. Humphrey of Fort Collins, Colo., and Dr. Carl Mundy of Toledo, Ohio, to its labors in behalf of better rural medical service.

Report of Committee on National Emergency Medical Service

Dr. E. L. Bortz, Chairman, presented the following report, which was referred to the Reference Committee on Emergency Medical Service, with the exception of the resolution, which was referred to the Reference Committee on Legislation and Public Relations:

The committee was created by action of the House of Delegates at its annual session in December 1945 to study the experiences of medical officers during the recent war. The following report was adopted:

> The Board of Trustees would recommend to the House of Delegates that it authorize the Board of Trustees of the American Medical Association to appoint a committee of seven to be known as the Committee on Military Service. This committee shall include four civilian physicians who served in the war and three others. The committee will study the many communications that have been received and the suggestions made by physicians in the armed forces. The committee will also formulate policies for recommendations to be forwarded through the Surgeons General to the Secretary of War and the Secretary of the Navy expressing the views of the medical profession in planning for proper utilization of the services of physicians in any national emergency.

Soon thereafter the Board of Trustees appointed the following committee: Dr. Perrin H. Long, Army; Dr. Harold C. Lueth, Army; Dr. Edward L. Bortz, Navy; Dr. James C. Sargent, Navy; Dr. Harold S. Diehl, Procurement and Assignment Service; Dr. O. O. Miller, civilian physicians groups; Dr. V. C. Tisdal, civilian physicians groups. Each of these individuals brought a different point of view to the deliberations of the committee.

The first meeting of the committee, which was an organization meeting, was held March 15, 1946. A considerable number of letters had been sent to the American Medical Association by medical officers drawing attention to certain disturbing problems in the medical activities of the armed forces. The committee reviewed these, and plans to correlate the data contained in them with the results of the questionnaire which is now being distributed.

The committee was of the opinion that a number of problems of importance to the studies were not encompassed in the original title of the committee, i. e., Committee on Military Medical Service, and therefore it was recommended that the Board of Trustees create a new title; accordingly the name was changed to Committee on National Emergency Medical Service. In this way certain aspects of premedical and medical education, activities of the Procurement and Assignment Service and medical care for the civilian population are included in the scope of the committee's investigations.

Your committee desires to state that from the beginning the committee has had the utmost cooperation, assistance and stimulation from the General Manager, Dr. George F. Lull, and the entire Board of Trustees.

On April 26, 1946, the committee met with Surgeon General Kirk and his staff, Surgeon General McIntire, Dr. Warren Draper, Deputy Surgeon General of the United States Public Health Service, and Dr. J. B. Mason, a representative of the Medical Department of the Veterans Administration, for a discussion of certain problems which the committee believed to be important. These included some comments on changes which were at that time under consideration by the medical departments of the Army, the Navy and the United States Public Health Service. The reports of this conference are in the files of the committee and open to any member of the House of Delegates who desires to study them.

A resolution presented to the House of Delegates in December 1945 suggested an investigation of the experiences of medical officers in World War II and recommended that a questionnaire be sent out. This recommendation precipitated the problem of obtaining the most important factual data by means of a questionnaire which would be of value to the committee in ascertaining the degree of utilization of the medical manpower during the war. The mechanics of formulation, distribution, collection and classification of the material made available through the questionnaire has been an expensive procedure and required a trained expert staff for its consummation. The committee was fortunate in obtaining the services of Mrs. Frances Tofield as secretary to the committee, and Dr. Frank G. Dickinson, professional economist, who has just recently become a member of the staff of the American Medical Association.

A pilot questionnaire was sent to 1,000 former medical officers whose names were selected at random. The response was surprisingly large, 470, or 47 per cent, of the questionnaires being carefully filled out and returned to the committee. With the pilot study as a preliminary step, a revised questionnaire was drawn up. These questionnaires are now being distributed to about 50,000 former medical officers, some of whom are still in uniform.

The response to this postwar questionnaire is exceeding expectations. Up to Dec. 6, 1946, 18,000 returned questionnaires had been received . . . exactly three weeks after the mailing of the questionnaires started. Four fifths of the questionnaires are signed, and 1 physician out of 50 attached a letter to his returned questionnaire.

Letters were mailed to 355 key men throughout the country for their "opinion viewpoint" during November, and 85 replies had been received by November 30. The information obtained from letters to these key men will likewise be classified.

The committee desires to discuss its findings with the surgeons general of the three governmental services and the Chief of

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the Bureau of Medicine and Surgery of the Veterans Administration before submitting its final report to the House of Delegates.

During the course of the committee's deliberations the relationship between the functions of the surgeons general to the civilian medical personnel was discussed.

The selection of men to be surgeons general should, our committee maintains, be made from those available men who are eminently qualified by experience and broad professional contacts and who possess the confidence of the medical profession of the nation on whom they must depend for support.

The following resolution is presented by the committee:

WHEREAS, The development of a strong and attractive medical service in the Army, the Navy, the Public Health Service and the Veterans Administration is in the best interests of the public welfare; and

WHEREAS, The development of such services depends on the confidence and intimate collaboration of the medical profession of the nation; and

WHEREAS, In time of national emergency the Medical Corps of the armed services requires the enlistment of a large number of doctors recruited from civilian practice; therefore be it

Resolved, That the House of Delegates of the American Medical Association recommend the appointment by the Board of Trustees of the American Medical Association of a committee, or committees, of distinguished American physicians who will, as occasion arises, study the qualifications of men available for the positions of Surgeon General of the Army, Navy, Public Health Service or Veterans Administration and advise the President of the United States of their considered judgment.

Respectfully submitted,

EDWARD L. BORTZ, Chairman,
HAROLD C. LUETH.
PERRIN H. LONG.
JAMES C. SARGENT.
HAROLD S. DIEHL.
O. O. MILLER.
V. C. TISDAL.

Report of Committee to Consider Revision of the Constitution and By-Laws

Dr. F. F. Borzell, Chairman, requested permission to present the report of the Committee to Consider Revision of the Constitution and By-Laws on Tuesday morning, which was granted.

Report of Joint Committee for the Coordination of Medical Activities (Committee on Postwar Medical Service)

Dr. E. E. Irons, Chairman, presented the following report, which was referred to the Reference Committee on Medical Education:

Following the expressed wish of the House of Delegates, with the concurrence of the Board of Trustees, that the Committee on Postwar Medical Service be continued, a recommendation for continuance was made to the other organizations represented in the committee and was agreed to unanimously. It was recognized, however, that new conditions evidently are arising and the content of the committee's deliberations changing. With this in mind, the name has been changed to Joint Committee for the Coordination of Medical Activities. The Joint Committee, as was the Committee on Postwar Medical Service, is made up of committees of the American Medical Association, the American College of Surgeons and the American College of Physicians and of individual "liaison" members representing the following organizations and agencies: Advisory Board for Medical Specialties; American Dental Association; American Hospital Association; Association of American Medical Colleges; Catholic Hospital Association; Federation of State Medical Boards; U. S. Public Health Service; Veterans Administration; Federal Security Agency; War Department Office of the Surgeon General; Navy Department, Bureau of Medicine and Surgery.

It is well understood by all members of the committee and the organizations which they represent that the work of this committee is advisory only. However, the committee does afford a forum in which the widely diverse problems of American medicine can be discussed in a friendly atmosphere and, where situations justify it, the committee can exercise a considerable influence toward the accomplishment of desirable objectives.

Among the problems which undoubtedly still will require consideration are those of postwar training of veteran physicians and the development of further residency and postgraduate opportunities. Problems of licensure and of medical service in rural communities also are occupying the attention of the committee.

Respectfully submitted,

ERNEST E. IRONS, Chairman.

NEW BUSINESS

Resolution on Closer Cooperation Between the Medical and Dental Professions

Dr. C. B. Conklin, District of Columbia, presented the following resolution, which was referred to the Reference Committee on Medical Education:

WHEREAS, The medical and dental professions have a common interest in the extension of health service; and

WHEREAS, There is need for closer cooperation between these professional bodies; and

WHEREAS, The president of the American Dental Association in recognition of this fact has appointed a committee of five dentists to cooperate with a similar number of representatives from the American Medical Association; be it therefore

Resolved, That this House of Delegates authorize the President to appoint a committee of five members of the American Medical Association to cooperate with a similar committee of the American Dental Association and that each state medical association be also urged to appoint a committee for the purpose of bringing about closer cooperation between physicians and dentists.

Resolution on Requirements for Approval of Hospitals

Dr. E. V. Askey, California, presented the following resolution, which was referred to the Reference Committee on Medical Education:

WHEREAS, The problem of hospitalization is urgent now and will be distressingly difficult for an indefinite period of time; and

WHEREAS, There is apparently a definite plan to limit staff membership in hospitals to diplomates of the various specialty boards; and

WHEREAS, The limiting of staff memberships and heads of departments of such staffs in hospitals to such diplomates could tend to injure the best interests of the public and the medical profession as a whole; and

WHEREAS, Of a total of 180,000 physicians in the United States approximately only 22,000 are diplomates of all specialty boards, and limitation by the hospitals of their facilities to use by these few would work an injustice on other capable doctors and their patients; therefore be it

Resolved, That the House of Delegates of the American Medical Association suggests to the Council on Medical Education and Hospitals and directs it to further the realization of this suggestion, to wit:

The requirements for approval of hospitals shall be so defined that there shall be (1) adequate protection of the rights of all doctors and their patients in obtaining hospitalization to the end that general practitioners as well as specialists shall have access to and use of hospital facilities; (2) that the criterion of whether a doctor may be a member of a staff or a head of a department shall be his actual ability as a doctor and not dependent on special society or board membership, and (3) that the American College of Surgeons be urged to conform to these general policies in their procedures in the standardization of hospitals.

Resolution on Sponsoring a National Conference of Officers of County Medical Societies

Dr. H. G. Hamer, on behalf of the Indiana delegation, presented the following resolution, which was referred to the Reference Committee on Legislation and Public Relations:

WHEREAS, Public relations, as pertains to organized medicine, has a most important field of effort in reaching and giving information to and receiving suggestions from the rank and file of doctors who give medical service to the public the country over; and

WHEREAS, Efforts in this direction have been so successfully carried on by the secretaries' conferences sponsored by several of the state medical societies; and

WHEREAS, There is no national group at present functioning in this capacity; therefore be it

Resolved, That the American Medical Association sponsor a national conference of officers of county medical societies which shall meet yearly just preceding the annual session of the House of Delegates of the American Medical Association for the purpose of bringing to the annual session the diverse problems of the various localities, the exchange of ideas which would be helpful to the state conferences, in such matters as voluntary health insurance plans, hospitalization plans, construction of new hospitals in needed places and improvement in medical facilities, rural health activities, nursing activities and the activities of the various Councils of the American Medical Association.

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Resolution on Fellowship of Members of Permanent Corps of Veterans Administration

Dr. E. H. Cary, Texas, presented the following letter and resolutions, which were referred to the Reference Committee on Legislation and Public Relations, except the part referring to amendments to the Constitution and By-Laws, which was referred to the Reference Committee on Amendments to the Constitution and By-Laws:

VETERANS ADMINISTRATION
Washington 25, D. C.
December 4, 1946

Department of Medicine and Surgery
In Reply Refer to: 10CE

Dr. Edward H. Cary
1717 Pacific Avenue
Dallas, Texas

Dear Doctor Cary:

There will probably be introduced at the coming meeting of the House of Delegates, American Medical Association in Chicago, a resolution which will allow the doctors of the permanent staff of the VA to become members of the American Medical Association in the same class with the Army and Navy medical personnel.

Previous to this in some places the Veterans Administration doctors were not allowed to become members of the A. M. A. because they were not considered to have been in practice in the state for at least a year, which, I understand, is a rule in some medical societies. Therefore, in many cases our men felt that they were not a part of the American medical profession and were outside the pale. This, of course, is not healthy for either the medical profession or the full time medical staff of the VA. Veterans Administration policy is not to allow full time VA doctors to practice medicine outside of their VA duties and therefore they cannot engage in private practice except when called by a practicing physician in consultation or in an emergency. Consequently, many of them will be excluded from membership in the Association.

As you know, there are now about 1,000 residents in training within the VA hospitals. In order to complete their training it is necessary in many cases for them to have two years of practice and we would like to keep them in the VA hospitals for these two years to serve the veterans confined in the hospitals. These are all men licensed to practice medicine in some state, and if they do not have the advantage of becoming members of the A. M. A. many of them will feel that the two years of practice within the VA is a handicap rather than a privilege. We would very much like to have a resolution passed that will give them the privilege of joining the rest of the medical profession in its national associations. These men are all veterans who had their medical training interrupted by their military service. Most of them are not settled in any locality permanently and have not made up their minds where they want to settle. Therefore it would be difficult for them to come under the year's practice rule unless the A. M. A. gives them the advantage of membership before they have done this year of practice outside the VA hospitals.

We also wish to give our full time men the advantage of close association with the medical profession in their various localities and also give the men devoting their time to private practice the educational advantages which we are offering and intend to continue to offer the VA medical staff. If they could all feel that they were part of the same family, I feel sure that it would result in great benefit to the civilian medical profession and to those associated with the Veterans Administration.

I hope you can see your way clear to promote this resolution for the benefit of all concerned.

Sincerely yours,

PAUL B. MAGNUSON, M.D.
Acting Assistant Medical Director
for Research and Education.

WHEREAS, The Veterans Administration as now constituted has an organized medical staff specifically constituted by an act of Congress; and

WHEREAS, The number of veterans entitled to medical care because of service connected disabilities is exceedingly great; and

WHEREAS, The Veterans Administration has sought the advice and cooperated with the American Medical Association in developing methods of administering medical care to the veterans; and

WHEREAS, Such problems are likely to continue for many years and are of considerable importance to the medical profession; and

WHEREAS, It would aid in the presentation and consideration of such problems if there were available in the House of Delegates a representative of the Veterans Administration as the Army and Navy medical departments and the U. S. Public Health Service are now represented; and

WHEREAS, Transfer of the permanent corps of the Veterans Administration to various installations widespread throughout the country makes difficult the securing and holding of membership of such members of the permanent staff in county and state medical societies; therefore be it

Resolved, That members of the permanent corps of the Veterans Administration be permitted to apply for Fellowship in the American Medical Association without payment of dues, with the understanding that such Fellowship shall continue as long as the physician concerned continues to be a member of the permanent medical corps of the Veterans Administration and that it does not involve subscription to THE JOURNAL or other publications of the American Medical Association; and be it further

Resolved, That the following amendments to the Constitution and By-Laws be considered by the House of Delegates with a view to making this action effective:

CONSTITUTION AND BY-LAWS

ARTICLE 5.—HOUSE OF DELEGATES

"SECTION 2.—COMPOSITION.—The House of Delegates is composed of delegates elected by the constituent associations and by the sections of the Scientific Assembly, and of delegates from the Medical Department of the Army and the Navy and the Public Health Service, appointed by the Surgeon General of the respective department . . ." should be changed to read

"SECTION 2.—COMPOSITION.—The House of Delegates is composed of delegates elected by the constituent associations and by the sections of the Scientific Assembly, and of delegates from the Medical Department of the Army and the Navy, the Public Health Service and the Veterans Administration, appointed by the Surgeon General of the respective department . . ."

ARTICLE 5.—HOUSE OF DELEGATES

"SECTION 3.—The total voting membership of the House of Delegates shall not exceed 175. The Medical Department of the Army and the Navy, the United States Public Health Service and the scientific sections shall each be entitled to one delegate . . ." should be changed to read

"SECTION 3.—The total voting membership of the House of Delegates shall not exceed 175. The Medical Department of the Army, of the Navy, of the United States Public Health Service and of the Veterans Administration and the scientific sections shall each be entitled to one delegate . . ."

BY-LAWS

CHAPTER 1.—SEC. 2. TERM.—Insert before the last line "Veterans Administration."

Resolution on Study of Child Health Services by American Academy of Pediatrics

Dr. William Weston, Section on Pediatrics, presented the following resolution, which was referred to the Reference Committee on Medical Education.

WHEREAS, The American Academy of Pediatrics is making a nationwide study of child health services; and

WHEREAS, The members of the American Academy of Pediatrics are all members of the American Medical Association; and

WHEREAS, The purpose and objectives and the scope of study undertaken by the American Academy of Pediatrics conform with the ten point program of the American Medical Association for the constructive health of the American people; and

WHEREAS, This study has been approved by many state medical societies; therefore be it

Resolved, That this study being made by the American Academy of Pediatrics be called to the attention of the House of Delegates of the American Medical Association, that the purpose, objectives, scope and method of study be reviewed by the House of Delegates and that the House of Delegates give its approval to this study.

Resolution on Standards Required for Certification by the Specialty Boards

Dr. William Weston, Section on Pediatrics, presented the following resolutions, which were referred to the Reference Committee on Medical Education:

WHEREAS, The American Medical Association by its rating of institutions according to specialty board certification of its staff members, is directly and indirectly a sponsor of the various specialty boards; and

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WHEREAS, These boards have apparently adopted a policy of increasingly difficult examinations, even delving into detailed pathology, embryology, physiology and physiochemistry; and

WHEREAS, Many of the examination questions can be more easily answered by recent graduates than by a well qualified specialist who has not had formal courses of study in some years; and

WHEREAS, This attitude on the part of the board is discouraging to a great number of competent, capable and even skilful men who, in order to avoid the onus of a possible failure, now refuse to apply for certification and thereby deprive recognized hospitals of their service on their staff; and

WHEREAS, There is a well integrated rumor to the effect that members of certain boards have expressed a determination that the servicemen returning will not find it easy to attain a certification; therefore be it

Resolved, That the said members of the specialty boards be requested to give serious consideration to the acceptance of men who have fifteen to twenty-five and more years solely devoted to their specialty, without demanding too much detailed knowledge of subjects long ago studied; and be it further

Resolved, That the members of said boards be asked to recognize the fact that many contemporaries of servicemen were granted their certification under less difficult and detailed examination while these men were in service and not able to attend the meetings of their boards. And in consideration of this to lighten, rather than make more difficult, entry of ex-servicemen to the boards, especially when the boards have written evidence from colleagues in the applicant's own community testifying as to the applicant's standing in his specialty.

Resolution on Change of Policy of American Specialty Boards

Dr. William H. Halley, on behalf of the Colorado delegation, presented the following resolution, which was referred to the Reference Committee on Medical Education:

WHEREAS, Certain of the American specialty boards have recently announced discontinuance of their former practice of according credit for preceptorships with a certified diplomate and have ruled instead that every applicant for certification must serve a lengthy residency following his internship; and

WHEREAS, This recent change in policy constitutes an unfair imposition on many returned medical veterans and other young physicians who find it impossible to obtain such residencies; and

WHEREAS, It is the opinion of the American Medical Association that the preceptorship is one of the best methods of teaching the art of medicine; and

WHEREAS, Qualified and experienced preceptors already certified by these boards are available in all parts of the United States; and

WHEREAS, The art of medicine is frequently neglected in hospital residencies due to overemphasis on the science of medicine; now therefore be it

Resolved, That the House of Delegates of the American Medical Association requests the Advisory Board for Medical Specialties and the several American specialty boards to review and reconsider their policies in relation to residencies and preceptorships in accordance with the foregoing statements.

Resolution on Appointment of Reference Committees

Dr. William H. Halley, Colorado, presented the following resolution, which was referred to the Reference Committee on Rules and Order of Business:

WHEREAS, The By-Laws of the American Medical Association contemplate the appointment of House of Delegates reference committees from the membership of the House of Delegates; and

WHEREAS, The duty of reference committees to pass judgment on the activities of elected and appointed officers makes it obviously improper for these committees to be composed of the persons whose actions they are expected to judge; and

WHEREAS, In recent years the Board of Trustees of the American Medical Association has acted as a reference committee of the American Medical Association House of Delegates to pass judgment for the House of Delegates on actions previously taken by the Board of Trustees; and

WHEREAS, Official protest of this action has been received from the Colorado State Medical Society; now therefore be it

Resolved, That the House of Delegates of the American Medical Association instructs its speaker to utilize as reference committees of this House of Delegates only committees composed exclusively of elected delegates.

Resolution on Prohibition of Political Activity on Part of United States Public Health Service

Dr. William H. Halley, Colorado, presented the following resolution, which was referred to the Reference Committee on Legislation and Public Relations:

WHEREAS, The United States Public Health Service was created organized and is amply financed for certain specific purposes, namely the promotion of the public health, the prevention of disease, the control of epidemics and the extension of help and advice to state and local communities in these and similar problems of disease prevention; and

WHEREAS, The United States Public Health Service in wartime has certain additional duties and functions related to the armed forces in assisting them in protection of the nation and its citizens; and

WHEREAS, Existing federal laws contemplate that regular officers of the United States Public Health Service shall devote their full time to the aforementioned duties; and

WHEREAS, Certain officers and members of the United States Public Health Service, including its Surgeon General, have within the last year so put aside consideration of the functions and duties for which they were appointed and commissioned as to devote much of their time and energy to political activities, even to the extent that the Surgeon General of that Service has issued written orders to his staff and his officers directing their utterances and thinking on highly controversial questions of medical legislation wholly unrelated to the proper functions of the United States Public Health Service and in opposition to American democratic processes; now therefore be it

Resolved, That the House of Delegates of the American Medical Association condemns without qualification, as a perversion of function and dereliction of duty, political and partisan activities on the part of officers of the United States Public Health Service, including its Surgeon General, and recommends that steps be taken to prohibit political activity on the part of the United States Public Health Service, and that further steps be taken to restore the prestige of this important department of our government in the scientific field for which it was created, organized and financed.

Motion on Mimeographed Resolutions

Dr. A. A. Walker, Alabama, moved that, in view of the fact that the members of the House of Delegates have mimeographed copies of some of these resolutions for their edification and education, the reading of such mimeographed resolutions be dispensed with at this time except by title and that they be referred directly to the reference committees, and the motion was seconded by Dr. A. S. Giordano, Indiana. Dr. Walker accepted an amendment that the reading of such resolutions be dispensed with unless there be an addition to the mimeographed copy of the resolution, and the motion as amended was carried.

Resolution on Rich Report

Dr. James P. Kerby, Utah, presented the following resolution, which had already been taken care of and which the Speaker announced would be taken up in the Committee of the Whole:

WHEREAS, The American Medical Association has had a complete and presumably competent survey of its public relations made by the Rich Associates; and

WHEREAS, The report of the Rich Associates apparently contains rather sweeping recommendations; and

WHEREAS, The contents of this report are unknown to the House of Delegates of the American Medical Association in spite of the fact that said House is the policy making body of the American Medical Association; and

WHEREAS, It is believed to be unwise for the House of Delegates to approve changes in the American Medical Association without knowledge of what it is that it approves; be it

Resolved, That the delegate to the American Medical Association is hereby instructed to take such action in the House of Delegates of the American Medical Association as will result in the members of that House becoming informed as to the contents of the so-called Rich report of the Rich Associates.

Resolution on Referring all Business to Reference Committees

Dr. James P. Kerby, Utah, presented the following resolution, which was referred to the Reference Committee on Medical Education:

WHEREAS, At the last meeting of the House of Delegates of the American Medical Association numerous matters were referred to the Board of Trustees as a reference committee; and

WHEREAS, At least one question was referred to the Judicial Council as a reference committee; and

WHEREAS, The By-Laws of the American Medical Association clearly set forth the constitution, manner of appointment and duties of the reference committees of the House; and

WHEREAS, It appears improper that a standing committee of the Association should act as a reference committee to review its own actions; be it

Resolved, That the delegate to the American Medical Association is hereby directed to take such action in the said House as will result in all business of the House of Delegates being referred to the reference committees of the House in accordance with the By-Laws of the American Medical Association.

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Resolution on American Medical Association Contribution to Health Education Projects

Dr. T. K. Gruber, for the Michigan delegation, presented the following resolutions, which were referred to the Reference Committee on Medical Education:

WHEREAS, The Michigan State Medical Society has supported a program of health education during the past five years; and

WHEREAS, Such health education is not purely of local but also of national interest and value; therefore be it

Resolved, That the delegates of the Michigan State Medical Society to the American Medical Association be instructed to initiate a study of a policy by which the American Medical Association could contribute a portion of the cost of such a program of health education carried on by any state medical society.

Resolutions on Establishment of General Practice Sections in Approved Hospitals

Dr. T. K. Gruber, for the Michigan delegation, presented the following resolutions, which were referred to the Reference Committee on Medical Education:

WHEREAS, The House of Delegates of the American Medical Association has established an individual section on the general practice of medicine; and

WHEREAS, The general practitioner has been recognized as a separate branch in the medical profession; and

WHEREAS, This group has shown its interest in this section by registering 939 members in the section at the 1946 American Medical Association meeting in San Francisco; and

WHEREAS, Their scientific section meetings were well attended; and

WHEREAS, The House of Delegates has already voiced its approval of such sections in the separate state and county societies that are component parts of the American Medical Association; and

WHEREAS, Sections on general practice have been started in some recognized hospitals that are approved by the American College of Surgeons and the Council on Medical Education and Hospitals and have been accepted by those bodies; and

WHEREAS, Many hospitals have not established general practice sections in their visiting active staffs and their governing heads are doubtful whether such action has the approval of the bodies which set up the rules and regulations for the approval of their hospitals for interns and residents; therefore be it

Resolved, That the delegates of the Michigan State Medical Society in convention assembled voice their approval of the establishment of sections of general practice in approved hospitals and that the delegates from Michigan to the American Medical Association House of Delegates introduce a similar resolution at the next meeting, requesting approval of that body; and be it further

Resolved, That a copy of this resolution be sent to the Hospital Committee of the American College of Surgeons with a request that that body voice approval of such sections and include such in its manual of Hospital Regulations.

Resolutions on Establishment of Certifying Board to Determine Qualification for General Practice

Dr. T. K. Gruber, Michigan, presented the following resolutions, which were referred to the Reference Committee on Medical Education:

Resolved, That the Speaker of the House of Delegates appoint a committee consisting of five members to formulate and recommend a plan for the establishment of a certifying board to determine qualifications for general practice; and be it further

Resolved, That the committee be requested to report at the next meeting of the House of Delegates in June at Atlantic City.

Resolution on Intern and Resident Medical Training

Dr. A. S. Giordano, Indiana, presented the following resolution, which was referred to the Reference Committee on Medical Education:

WHEREAS, The primary objective of intern and resident medical training is medical education; and

WHEREAS, The acceptability of internships and residencies in hospitals should be founded on the excellence of their teaching programs; and

WHEREAS, The number of hospitals approved for intern and resident training exceeds the number of available interns and residents; and

WHEREAS, Such disparity has forced hospitals to compete for applicants for training on monetary rather than on educational opportunities; therefore be it

Resolved, That a reasonable and uniform maximum figure for the remuneration of interns and residents be established, so that the monetary value of internships and residencies may not act as a deciding factor in the applicants for such training.

Resolutions on Evidence of Practice of Medicine

Dr. Henry S. Ruth, Section on Anesthesiology, presented the following resolutions, which were referred to the Reference Committee on Miscellaneous Business:

WHEREAS, The accepted method of notification of the amount of recompense indicated for medical service rendered consists in presentation to the patient or responsible party of a statement or bill for the same; and

WHEREAS, The amount involved has been established over a long period on an individual basis between the physician and the patient; and

WHEREAS, The fee rendered is usually based on the duration of service in time and effort, responsibility involved, material expenditures, the financial status of the patient and the qualifications of the physician; and

WHEREAS, The practice of anesthesiology as well as other specialties has been defined by the American Medical Association as the "practice of medicine"; therefore, be it

Resolved, That the presentation of bills and the collection of private fees for medical service rendered by other than recognized physicians be hereby established as evidence of the practice of medicine; and be it further

Resolved, That persons sending such bills shall be liable to the penalties set forth in the medical practice acts and/or laws pertaining to medical education regulating the practice of medicine.

Resolution on Morton Centenary

Dr. Henry S. Ruth, Section on Anesthesiology, presented the following resolution, which was referred to the Reference Committee on Miscellaneous Business:

WHEREAS, The year 1946 marks the one hundredth anniversary of the first public demonstration of the use of ether as an anesthetic agent by W. T. G. Morton on Oct. 16, 1846 in the Massachusetts General Hospital in Boston; and

WHEREAS, This event represents one of the most important steps in medical history; therefore be it

Resolved, That the American Medical Association cooperate with the American Society of Anesthesiologists and other acceptable medical organizations in programs celebrating this centenary.

Resolution on Bituminous Coal Mine Wage Agreement

Dr. Clark Bailey, Kentucky, presented the following resolution, which was referred to the Reference Committee on Executive Session:

WHEREAS, As a result of a resolution presented at the last session of the House of Delegates of the American Medical Association in regard to the problems of medical practice in the coal mining areas brought about by the bituminous coal mine wage agreement the Council on Medical Service was directed to cooperate with the mine physicians in these areas; and

WHEREAS, The physicians in the coal mining areas have been greatly benefited by the advice and interest of the members of the Council on Medical Service with the cooperation of the Council on Industrial Health; and

WHEREAS, There has been established an active relationship between coal mine physicians and these Councils of the American Medical Association; and

WHEREAS, As a recent grave crisis of a national character emphasizes the need for the continuance of the close relationships with the mine physicians; and

WHEREAS, The results of the survey stipulated in the wage agreement, of health, housing and sanitary conditions in the mine areas, will demand constructive medical leadership; therefore be it

Resolved, That the Council on Medical Service and the Council on Industrial Health be directed to continue close cooperation with the mine physicians in an effort to maintain and improve the high standards of medical practice.

Resolution on Teaching of Preventive Medicine and Public Health

Dr. William D. Stovall, Wisconsin, presented the following resolution, which was referred to the Reference Committee on Medical Education:

WHEREAS, The professional literature is emphasizing preventive medicine as the advance of modern medicine;

WHEREAS, Groups concerned with administrative practices applicable to the control and prevention of disease are anxious that preventive medicine receive special recognition in the medical school curriculum;

WHEREAS, The technical methods for practice of preventive medicine and those for the practice of general medicine are not sharply differentiated in medical teaching;

WHEREAS, The concepts of preventive medicine arise from technical practices for disease control by prophylactic immunization, by the diagnosis and adequate treatment of incipient disease and functional disorders, and by environmental control;

WHEREAS, The introduction of additional subjects and more teaching hours into an already crowded medical curriculum is difficult;

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WHEREAS, The American Medical Association over the years has been active in advancing medical education to meet the progress of medical science and setting the standards for medical education in this country; therefore be it

Resolved, That the Council on Medical Education and Hospitals of the American Medical Association be requested to restudy the teaching of preventive medicine and public health to undergraduate medical students to determine the methods used in various medical schools in this country and Canada to determine the subject matter covered in such teaching.

Distribution of "Rich Report"

Copies of the "Rich Report" and the report of the special committee to study it were distributed by roll call.

The House recessed at 1:20 p. m. to reconvene Tuesday morning at 9:30.

Second Meeting—Tuesday Morning, December 10

The House of Delegates was called to order at 9:40 a. m. by the Speaker, Dr. R. W. Fouts.

Roll Call

On motion duly made, seconded and carried, the House directed that the report of the Reference Committee on Credentials for this day constitute the roll call.

Presentation of Minutes

It was moved by Dr. William Weston, Section on Pediatrics, seconded by Dr. Thomas S. Cullen, Maryland, and carried, that the House dispense with the reading of the minutes.

Report of Reference Committee on Credentials

Dr. G. Henry Mundt, chairman, announced that 167 delegates had been registered, and the speaker stated that a quorum was present and the House was ready to proceed with business.

Reconsideration of Third Recommendation in Report of Special Committee to Study the "Rich Report"

The Speaker announced that two distinguished visitors were present, one of whom wished his address given in executive session and would have to be heard at 10:30 a. m.

On motion by Dr. John W. Cline, California, seconded by Dr. William Weston, Section on Pediatrics, and carried, the recommendation adopted yesterday, reading "That it be considered by this House at that time in Executive Session limited to members of the House of Delegates and officers of the Association, acting as a Committee of the Whole" was rescinded.

Dr. John W. Cline, California, moved that the House reconsider the motion to make consideration of the Rich Report the first order of business this morning. The motion was seconded by Dr. Harry Aranow, New York, and carried.

Address of Dr. T. C. Routley

The Speaker introduced Dr. T. C. Routley, Secretary of the Canadian Medical Association, who addressed the House as follows:

Mr. Speaker, Ladies and Gentlemen:

For twenty-four years you have received me most cordially, and I regret exceedingly that circumstances did not make it possible for me to be with you at your San Francisco session. I would like to take one moment, if I may, and tell you, as the Chairman has instructed, why I missed your San Francisco session.

The government of Canada, as one of the invited nations to the United Nations International Congress on Health, invited the General Secretary of the Canadian Medical Association to act as one of its medical advisers. So for a period of five months I enjoyed the hospitality of New York. I didn't enjoy its humidity quite so much. But during that period I saw the formation of the World Health Organization as a structure set up by the United Nations. On completion of the structure, the government of Canada invited me to act as their representative on the Interim Commission, the body which has been charged with the responsibility of bringing the World Health Organization into being.

In the month of September the British Medical Association and the old Association Professionelle Internationale des Médicins which was organized in France decided there should be a conference on the medical profession of the world, and it was held in London. Again it was my privilege to be there.

Mr. Speaker, I am greatly privileged to have the opportunity to say to this governing body of the greatest medical association in the world that in my humble opinion two parallel streams have begun to flow, and I think their course might have some effect on the future of this world.

I believe that the World Health Organization set up by the United Nations offers an opportunity for the expression of good will and cooperation and world fellowship such as no other agency in the United Nations can do. But I submit to you, Mr. Speaker, that the World Health Organization without the vitalizing force of the medical profession of the world will be like an electric power line without electricity flowing through it.

I believe that we of the medical profession of the world have an opportunity because of our common belief in an ideal, because of our common objectives and because of our great belief in the ethics of our profession—we have an opportunity as a worldwide brotherhood—to demonstrate two things; first, that we can carry on as one world and second, that we believe in the brotherhood of man.

What would you think if the state of New York had only two physicians? Yet I have just come back from Geneva and heard Ethiopia and Liberia pointing out that with 12,600,000 population, they had two physicians between them. That is all. And I listened to the man from Czechoslovakia stating that the enemy liquidated—they never knew how—nearly 1,500 of their physicians.

I submit to you that today many parts of this world are suffering more than they ever did before. I submit to you gentlemen, that the medical profession has an opportunity not only to see that all mankind enjoys the highest possible level of health, but to demonstrate to a troubled world that man's humanity to man can transcend economic difficulties and that we can make this world safe for humanity.

I suggest to you that unless we go forward as one world we are going to go backward, and into utter chaos, as a divided world.

This great American Medical Association was quick to seize the opportunity of joining the World Medical Association. And may I speak, on behalf of the great American medical profession, appreciation of your hearty allegiance to and support of the efforts being put forward by this World Medical Association to make our profession what we think it can be all over the world. There is no desire, none whatever, to have the World Medical Association intrude itself into the private affairs of any nation. But, I think you will see quickly that there is an opportunity for physicians all over the world to assist one another.

Report of Reference Committee on Miscellaneous Business

1. Resolution on Morton Centenary: The Reference Committee on Miscellaneous Business recommends approval of this resolution as submitted yesterday.

2. Report of Committee on Military Rank: The Reference Committee recommends the continuation of the Committee on Military Rank and its activities as requested in the report of that Committee.

3. Resolutions on Evidence of Practice of Medicine: The reference committee offers the following substitute resolutions in place of those introduced on yesterday:

WHEREAS, The accepted method of notification of the amount of recompense indicated for medical service rendered consists in presentation to the patient or responsible party of a statement or bill for service rendered by the person rendering such service; and

WHEREAS, The amount involved has been established over a long period on an individual basis between the physician and the patient; and

WHEREAS, The fee rendered is usually based on the duration of service in time and effort, responsibility involved, material expenditures, the financial status of the patient and the qualifications of the physician; and

WHEREAS, The practice of anesthesiology has been defined by the American Medical Association as "the practice of medicine"; therefore be it

Resolved, That the House of Delegates of the American Medical Association reiterate its position that the administration of anesthesia constitutes the practice of medicine and the presentation of bills and the collection of private fees for such service rendered by others than recog-

nized practitioners of medicine shall be considered as the evidence of practice of medicine; and be it further

Resolved, That these resolutions be sent to the agencies of each state having jurisdiction for the enforcement of medical practice acts and also to the secretary of the state medical association of each state.

Respectfully submitted,

WILLIAM A. COVENTRY.
R. B. ANDERSON.
GEORGE A. WOODHOUSE.
WARREN L. ALLEE.
WILLIAM F. COSTELLO.

The first and second sections of the report of the reference committee were adopted on motions of Dr. Coventry, duly seconded and carried.

Dr. Coventry moved adoption of the third section of the report of the reference committee dealing with the Resolutions on Evidence of Practice of Medicine, and the motion was seconded by Dr. Robert E. Schlueter, Missouri. After discussion by several, it was moved by Dr. Walter E. Vest, West Virginia, and seconded by Dr. George W. Kosmak, New York, that this portion of the report be referred again to the reference committee for further consideration and report tomorrow. The motion was lost in a standing vote.

Dr. Thomas M. D'Angelo, New York, moved to amend the resolution of the reference committee by adding "This in no way applies to nurse anesthetists in hospitals under the jurisdiction of a properly qualified anesthesiologist," and the motion was seconded by Dr. J. Stanley Kenney, New York. After discussion by several, Dr. E. V. Askey, California, suggested that the proposed amendment be changed to read "This in no way applies to nurse anesthetists in hospitals under the direction, jurisdiction and responsibility of a regularly licensed doctor of medicine," and the suggestion was accepted by Dr. D'Angelo.

Dr. Coventry's motion to adopt the third section of the report of the reference committee was then adopted as amended.

On motion of Dr. Coventry, seconded by Dr. George W. Kosmak, New York, and carried, the report of the Reference Committee on Miscellaneous Business as amended was adopted as a whole.

Report of Reference Committee on Emergency Medical Service

Dr. Walter G. Phippen, Chairman, presented the following report, which was adopted on motion of Dr. Phippen, seconded by Dr. George W. Kosmak, New York, and carried:

Your reference committee has read the report of the Committee on National Emergency Medical Service, and commends the committee for its diligence and comprehension of the scope of its work.

It believes the change in title to "Committee on National Emergency Medical Service" is well taken.

The questionnaire sent to fifty thousand former medical officers seems very complete and comprehensive, and its final tabulation will be looked forward to with great interest.

The committee agrees that "The selection of men to be Surgeon Generals should be made from those available men who are eminently qualified by experience and broad professional contacts and who possess the confidence of the medical profession of the nation on whom they must depend for support."

We believe that more consideration must be given to the care of the civilian population in any future national emergency because of the change in the type of offensive and defensive warfare.

We would suggest that the committee amplify its field of study by sending questionnaires to an appropriate number of those physicians who maintained civilian practice during the trying war period.

The committee is again commended for its excellent report of progress.

Respectfully submitted,

WALTER G. PHIPPEN, Chairman.
C. B. CONKLIN.
STEPHEN E. GAVIN.
GEORGE BRAUNLICH.
GROVER C. PENBERTHY.
ARDEN FREER.
JOHN HARPER.

Executive Session

On motion of Dr. John W. Cline, California, seconded by Dr. Walter E. Vest, West Virginia, and carried after amendment, the House went into Executive Session granting permission to attend, in addition to the delegates, to officers of constituent state or component county medical societies, executive secretaries, any members of the American Medical Association present, editors of state medical journals and directors of councils and bureaus of the American Medical Association.

The House then recessed to go into Executive Session at 10:30 a. m.

Address of Rear Admiral J. T. Boone (MC), United States Navy

The Sergeants at Arms polled the House and announced that all present were entitled to be there.

Dr. George F. Lull, Secretary, introduced Rear Admiral J. T. Boone (MC), U. S. Navy, Medical Advisor for the Coal Mines Administrator, who presented the following address:

Dr. Fouts, General Lull, Ladies and Gentlemen:

Before I start my address, I regret very much that it is necessary to read it, since I would much prefer to talk it; but, as I shall explain, there are very definite reasons why I at this moment have to be extremely careful. This is not, in any sense, the report of the medical survey or a part of it. I think what I have to say will speak for itself and for the reason that I have to approach the subject as I am this morning.

When the gracious and courteous invitation to address the House of Delegates was received by me, it could not be foreseen that a second labor strike in a single year would occur in the bituminous coal industry, nor was it possible to anticipate the unfortunate circumstances of court action necessitated by the unilateral denunciation by the president of the United Mine Workers of America of the contract executed between himself and the Government. Under these conditions, my appearance before you at this particular time unfortunately presents a definite handicap in a presentation that I had hoped to be able to make. I had looked forward pleasantly to this meeting. I full well realize that you, Mr. Speaker, honored me distinctively when you extended the invitation for me to address the House of Delegates. I wish that I could feel worthy of the honor bestowed. It would have been a happy occasion could we have sat down together, as it were, and discussed, fully and frankly, observations that it has been my privilege to make of the medical care, hospitalization, sanitation, housing and community life of the great industry of coal. The change in the national picture, however, creates a cause for embarrassment. To put it in more common vernacular, I feel that I am very much on the spot. However, in coming before you I recognize that I, as a physician, have a service to render to my profession as well as a public duty to perform as an officer of the Government. I shall ask your indulgence and charitableness in my efforts to present certain problems in which I believe the profession of medicine is vitally concerned.

I might begin by identifying my personal background of interest in medicine so that there may be no illusions that, despite any critical remarks, I have anything but a reverence for my profession and, therefore, am zealous to safeguard its welfare. The seeds of my vocation were implanted in the earliest recollections of my youth. Never had I wished to be anything but a Doctor of Medicine, and at the termination of my career, regardless of all the tributes that might be accumulated by me in a life time, I hope to be remembered as just a Doctor of Medicine. Many hours of my youth were spent with an uncle of mine who was a physician and for whom I had and still have a deep affection. He inspired me in those horse and buggy days as I rode with him over the countryside while he went from house to house to care for his patients. The concept of "the family physician" always has been an ideal of mine.

I cannot but regret that the practice of medicine has wandered, drifted or been forced far afield from this concept which is based on the personal relationship of patient and physician. We are witnessing and are a part of great changes

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in our individual and community lives and in our relationships with one another. The rapid progress of science, technology and industry compels social change. The resulting complexities of life have conspired to force on us high degrees of specialization, in medicine as well as in other fields. Discomforting as such thoughts may be, it is wise as well as necessary that medicine be attuned to the cadence of the times.

We can justly be proud that medicine can so speedily and admirably adjust itself to new conditions. No better example can be afforded than the way it responded to the emergencies of the war. The war brought with it tremendous acceleration in medical practices due to the scientific advances and the new discoveries made in drug therapy, new surgical procedures and emergency measures applied on the field of battle. For the first time in history, a war had been fought (and this, as we know, was one that involved more people than any other) in which the incidence of disease in the armed forces was less than battle casualties. To medicine must belong the credit for this accomplishment and, I might add, to preventive medicine belongs the greatest credit. No less a leader than Admiral Halsey has told me in person that until we had conquered the mosquito and the fly in the South Pacific the combat forces were held at bay in that theater of operation. Owing to immunization, we had no tetanus to speak of in this war, and no one died of epidemic typhus. We had safe water to drink and noncontaminated foods to eat. We lived in tropical climes heavily disease-laden, foreign to our troops and sea forces, and yet, in spite of sundry debilitating and invaliding factors, our military forces fought successfully a war to victory with a minimum of handicap from disease.

The war brought about many changes. It brought with it new discoveries in chemotherapy, gave impetus to advanced surgical procedures and furthered public confidence in the profession of medicine. The war compelled us, however, temporarily to intensify and accelerate medical education. Further, more than sixty thousand physicians in the United States were swept out of their offices, from their home firesides and transformed, as it were, overnight into military entities. The civilian attire was suddenly replaced by the military uniforms of the nation. Physicians who had retired from private practice, relinquished their leisure and their hobbies to resume the active practice of medicine in a highly commendable effort to meet the needs of their communities. Then when the war ended and the period of too rapid demobilization set in, physicians again faced a tremendous problem of readjustment.

The war years also were accompanied by changes and dangers of a legislative nature. A welter of new laws, bills and regulations bearing directly on public health and medical and hospital care confronted the medical profession. I am in no position, as an officer of the United States Navy, to express any personal preferences, alternatives or aversions. But I also need not be a mystic to discern that some of the proposals that have been vigorously propounded meet with disfavor and considerable apprehension by large numbers of medical practitioners. It is important only to note and reemphasize that such proposals as have engendered a substantial degree of public support stem from the real, as well as imagined, needs of the people. They are symptoms of dissatisfaction with the medical profession as it practices its art today; and the physicians themselves should be the first to recognize these symptoms, diagnose the causes and prescribe remedies which will not merely allay the complaints but produce the cure.

These controversial issues will doubtless rise again in the new Congress. It is likely that organized medicine will again find itself in the embarrassing position of the Good Samaritan trying to explain his deeds. However, organized medicine must also be prepared to present unselfishly some rational solutions to the problems of rising costs of medical care; more equitable distribution of services and facilities; more rapid transfer of the benefits of laboratory and clinical research to the patient; greater spread of diagnostic aid; wider application of the technology of public health, industrial medicine and preventive medicine, and other health matters of public concern.

None of us should fear the pounding out on the anvil of public opinion of the great issues of the day. Those of us alined with medicine must expect that the problems affecting medical practice will be laid on that anvil. We must not fear it but be prepared to play a leading part in its forging. Organized medicine must, however, see to it that the debate is tempered by the record of past successful accomplishment and by logical reasoning, not hysteria and emotionalism. In other words the profession of medicine must be the guiding and stabilizing force; it must apply the art of treatment and, if possible, in order to avoid an emotional national imbalance, it must meet the issues of the day with the tolerant artistry of the physician. If medicine does not exhibit the leadership in the correction of abuses and the overcoming of its own deficiencies and demonstrate its willingness to improve, other forces less experienced and less competent will undertake the leadership. Organized medicine has a tremendous challenge to meet. If it does not maintain directional control, other forces outside of it are not only willing but are anxious to mold the destiny of the profession.

The survey of medical care, hospital and medical facilities and sanitary conditions in the coal mining areas of the nation, which I have been privileged to organize and direct, has called my attention to other issues facing the medical profession which, if narrower in scope than those I have already mentioned, are nonetheless of vital importance to a proficient and free medicine. For the benefit of those who have not had the opportunity of reading my paper which was published in the November 30 issue of THE JOURNAL of The American Medical Association, I should like to describe briefly the origin and scope of the coal industry survey which was initiated some six months ago and is now drawing to a close.

As you remember, the soft coal mines were closed down by a strike throughout April and most of May of the present year. When operations were resumed, the mines were under government control by order of the President of the United States, and their operation was vested in the Department of the Interior. The Secretary of the Interior, the Honorable J. A. Krug, called on Admiral Ben Moreell * of the Civil Engineer Corps, United States Navy, who had made a notable record in handling a similar situation in the oil industry last year, to become Federal Coal Mines Administrator. A week after Government seizure, Secretary Krug, with the assistance of Admiral Moreell, negotiated a contract with the miners' union which became effective May 29. Various provisions of this contract deal with health matters, among which is section five, which reads as follows:

> The Coal Mines Administrator undertakes to have made a comprehensive survey and study of the hospital and medical facilities, medical treatment, sanitary and housing conditions in the coal mining areas. The purpose of this survey will be to determine the character and scope of improvements which should be made to provide the mine workers of the Nation with medical, housing and sanitary facilities conforming to recognized American standards.

The Secretary of the Interior, with the approval of the President of the United States, selected me to serve as the Director of the Medical Survey. Commodore Charles T. Dickeman, Civil Engineer Corps, United States Navy, was selected and assigned as my principal assistant and engineering advisor. Medical, engineering and welfare and recreation officers of the Navy were assigned for the purpose of composing field surveying teams, five of which were organized and assigned to investigate selected mining communities in twenty-two of the twenty-six principal soft-coal mining states of the nation. These teams worked out of the five regional area offices of the Federal Coal Mines Administration with headquarters located in Pittsburgh; Ashland, Ky.; Chicago; Kansas City, Mo., and Denver, Colo.

I have been aware that wonderment has prevailed in some quarters as to why a *Naval* Medical Officer was directed to make such a survey. Neither I nor my Naval medical associates are officers of the United States Public Health Service, but public health is not an unfamiliar subject to the Naval Medical Corps. Throughout the history of that Corps, it has made repeated

* When Admiral Moreell desired to retire from active duty in the Navy, he resigned as Federal Coal Mines Administrator and was succeeded by his Deputy, Captain Norman H. Collisson, United States Naval Reserve.

investigations and taken corrective action on large scale public health matters in various parts of the world. Frequently, it has had to make foreign territory habitable for the armed forces of our country so that they might occupy and carry out their military obligations in varied climes and under varied conditions. The Navy serves from the Arctic to the Antarctic; in temperate, frigid and tropic zones. I might add, gentlemen, that the Naval Medical Corps also must pioneer many times to make it possible for our military personnel to work at great altitudes in the rarefied atmosphere, at great depths under the sea and in confined and crowded spaces in the ships on the surface of the sea. We of the Navy serve in shipyards which are great industrial plants. We, therefore, were enabled to approach our problem in the study to which I have referred not as the uninitiated in industrial health and in preventive or public health matters.

In organizing and conducting the survey the keynote was impartiality and objectivity. We approached the study without preconceived attitudes and without bias and have always maintained what we believe to have been strict impartiality. We were determined to obtain *facts* and to predicate conclusions solely on the basis of reliable information. In contradistinction to some other surveys, we were fortunate in that we could rely, in cases where statistical evidence was not obtainable, on professional people capable of making judicious appraisals. Further, we obtained excellent cooperation from management and labor, from state and community officials and from physicians on the valid promise that health is a common meeting ground for all who have a relationship with or are interested in the people in the great coal mining industry.

The allegation that there are subhealth standards in the bituminous coal industry prompted the Government to commit itself to making this survey. To medical practitioners it is obvious that there are subhealth standards in other industries also. However, our group had been ordered to give its attention only to the coal industry. Our investigation carried us personally into mine workings, physicians' offices, dispensaries, hospitals and schools and into the homes of miners in the states of Pennsylvania, West Virginia, Maryland, Kentucky, Virginia, Tennessee, Alabama, Ohio, Michigan, Indiana, Illinois, Iowa, Kansas, Missouri, Arkansas, Oklahoma, Colorado, Wyoming, Montana, New Mexico, Utah and Washington. It cannot be said that those of you physicians not practicing or living in the areas where coal is mined have no interest in the miner and his dependents. I am sure you are too broadminded to have any such concept. The health problem in the coal fields cannot be dismissed as a matter affecting less than 2 per cent of the population of the country or merely a few hundred physicians. What we have seen I can assure you is rightly a concern of the specialist in Chicago and New York as well as the general practitioner in the isolated Appalachian regions. As you well know, since diseases can become epidemics, diseases originating in rural and mining communities can be and frequently are spread to urban centers, to even those far removed from coal mining areas. The poor sanitation and apparent stream pollution in mining communities are matters of more than local concern. It is obvious to you gentlemen that illness and disease in one segment of the population can readily affect the health and welfare of the entire nation. I am sure, therefore, that you agree with me when I say that if we can help to raise the health standards of coal mining communities, we can contribute to improvement of the national well-being.

As the report of our findings still remains to be completed, it obviously would be premature and improper to reveal at this time our results and conclusions. However, to my associates in the practice of medicine, I feel it is not amiss to present some of my personal observations and impressions and to call to the attention of this most representative group some of the problems which seem to be a concern of organized medicine.

The apparent weaknesses in public health programs in the nation's coal mining regions are deeply disturbing. Elementary control measures, in many instances, are completely lacking. There are exceptions, of course, but I would guess that, as a general rule, coal-mining communities, particularly in the more densely populated and more heavily productive coal areas, are deficient in such essential measures as adequate water supply controls, proper disposal of sewage and garbage, reasonable safeguards against contamination from human and animal wastes, protection in food and milk handling and insect and rodent control measures. Although a number of coal-mining communities owned and operated by the larger and more progressive coal companies seem to be as sanitary and healthful as our better incorporated cities, they are too few in number and stand out as exceptions to the rule.

State departments of health and similar state agencies are, in most instances, aware of the problems, and some are making a strenuous effort to overcome them, but in a majority of cases, unfortunately, their efforts do not extend to coal communities. They are, however, severely handicapped. They are faced with shortcomings in their laws and with inadequacies in the powers of enforcement, particularly when many of these mining communities are privately owned property and not public or even semipublic properties. State health departments have not had, and do not now have, even with the federal financial assistance that has been given them in recent years, sufficient funds to carry out any but the most minimal programs. They are further seriously handicapped at the present time by inability to recruit trained personnel because of a definite shortage of professional people, and because of the relatively small salaries they are authorized to pay. On the county and local levels public health work is even more sporadic. A few of the coal counties have outstanding programs which are carried out by organized and trained staffs on a full time basis; other counties have no individual programs whatsoever or haphazard programs directed and carried out by part time personnel.

In the coal communities that I have visited, I have inquired into the participation in public health work by the "company" physician and other private practitioners and, I must say, I have been very disappointed to learn that, except for school health programs of immunization, physicians have evidenced very little interest in public health work and preventive medicine. These same physicians, as residents of the communities in which they practice, have not even as a rule undertaken their responsibilities as enlightened citizens and, shutting their eyes to the apparent stream pollution and closing their ears to the crying need for hygiene education of their fellow citizens, have withdrawn themselves into their work and their private lives. I full well realize the difficulties they face. They are extremely busy with the practice of curative medicine, their patient load probably being as high as that of any physician in the United States. They hesitate to assume a leadership in matters where there is little general understanding or willingness to understand. Nevertheless, their reluctance to show their concern and to participate beyond the confines of their own private practice is indicative of an attitude which is altogether too general.

I may be in error, but I cannot help having the feeling that there is a definite schism between curative medicine and preventive medicine. I am disturbed by the hiatus that exists between private practitioners and public health officials. All are men of medicine or closely related thereto. The common objective of private practitioners and the public health officials is the maintenance of the health of the people of the nation. Public health work in the coal-producing states and counties has broken down or rather, I should say, has never fully gotten under way because of an unfortunate lack of public understanding and public support. I believe that organized medicine can perform a noble task in closing the gap between curative medicine and preventive medicine and in assuming a greater degree of leadership in educating its own membership and the general public in the values of public health work; also it should stimulate and encourage the public to provide a greater measure of support for preventive health measures. I feel that every effort should be exerted to see that states and counties and other local jurisdictions have adequate legislation, reasonable enforcement authority and rounded out staffs of full time, not part time, health officers, sanitarians, visiting nurses and other trained personnel. Public health is not exclusively the concern of government.

Medical practice in coal mining communities throughout the United States has a traditional background. Various prepayment plans are in existence almost generally. The histories show that their origins are rooted in necessity. Coal-mining

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operations in many parts of the country began in isolated areas before the establishment of other communities or even ordinary means of public transportation. To attract physicians to these communities, it was necessary to guarantee them an income. This was done by "checking off" from the miners' wages a specified sum each pay day to provide for medical care. The coal company recruited the physician and provided him with office space. In some instances, the company paid him a salary of more or less money than the "check off" provided. In other instances, the entire sum of money obtained from the "check off" constituted the physician's guarantee.

Today, physicians who carry on their practices in coal-mining communities perform their duties under a variety of payment systems. In some cases, the physician is paid a straight salary by the company and limits his practice for the company to cases which are "compensable" under state laws. In other instances the doctor receives his principal fee under the "check off" system and, in addition to his general practice, handles accident cases for the company on a fee for service basis. The prepayment plans which are in existence today do not provide for complete coverage of the subscribers' ailments. The physician, under the prevailing systems, generally charges extra on a fee for service basis for maternity cases and for treatment of venereal diseases. He also generally charges extra for home calls to persons living outside the camp area, even though they are subscribers to the prepayment plan. In addition it is general for these "contract" or "list" physicians to practice on a fee for service basis among residents of the community who are not subscribers to the prepayment plan. There are many modifications of these systems, which the medical officers of our Survey Group have investigated and which will be described in the survey report that is now in preparation.

The prepayment medical care and hospitalization plans which are in existence in coal-mining communities can be very carefully scrutinized; and I am sure an overall study would be revealing and provocative. I feel it is a part of the obligations of organized medicine to know, if it does not know already, some of the situations which exist today. I cannot help but feel, as one who has visited and inspected many hospitals as part of my official duties, the tremendous variations in adequacy, appearance, safety and maintenance of hospitals. Unfortunately, too few states have adequate laws to license hospitals. If this were not so, I believe that the standards of the hospitals would be very much higher. It may be that the Hospital Survey and Construction Act will play an important part not only in providing more hospitals but in raising the qualities of the old as well as new hospitals, The Act should establish better standards which take cognizance of the requirements set by the medical profession.

I have, in previous discussions and in my talk before the Seventh Annual Congress on Industrial Health on October 1 in Boston, spoken of the lack of interest on the part of the practitioner in coal-mining communities in industrial health. While I do firmly believe that no physician can practice medicine effectively without a good understanding of the environmental conditions of his patients, I realize nevertheless that industrial medicine is a specialized branch of the medical arts. One should not, therefore, expect the physician in the coal-mining community who is engaged primarily in general practice to be thoroughly conversant with all the phases of industrial medicine as it applies to coal mining. This had better be left to the medical practitioner who is engaged specifically in the prevention and treatment of occupational illnesses and also sees the victim of industrial accidents prior to referral for definitive surgical care. Because the mine physician, as we know him today, is generally not familiar with the working environment of the miner and is not a specialist in industrial medicine, the preemployment examinations which he conducts in some instances at the request of the management have little value from the standpoint of proper placement of the job seeker. They are of benefit neither to the man whom he may be called on later to treat, nor to the employer who is concerned with the proper placement of persons; they are attached as primarily of use as a means of conclusion. As applied now they contribute little to preventive medicine, but they can be potent and constructive factors. It may be hoped, however, that, with the end of the war and the better possibility of recruiting additional physicians into the mine areas to alleviate the burdens of the present practitioners, mine physicians will have more time and will, through their own initiative and through their organization, take a greater interest in the environmental conditions of the miners in order to improve medical practice in the mining communities.

The luxury of criticism is one in which we all love to indulge. The coal-mining physician has had his share of criticism. The mere fact that medical practice in some coal-mining communities can be a lucrative business does not mean that the profession as a whole is interested primarily in making money. There are a number of men in the coal-mining communities who could do as well or better elsewhere, yet remain in these communities out of a spirit of service to the people and devotion to their profession. I will confess that the instances in which I have observed this are more rare than I would like to see, but they are, nevertheless, comforting to me and I am sure to all of us who love the medical profession. It is inspiring to a medical practitioner to relearn occasionally that the missionary spirit still exists in the profession.

Unfortunately, missionary zeal does not always go hand in hand with competence and progress. That is one of the penalties of conducting a medical practice in a relatively isolated area. Because of the assured income that results from the prepayment system which is common and traditional in the coal-mining industry, many young men who need a start in their profession have a unique opportunity to begin their careers in those areas. Where advantage is taken of such opportunities by young men who are starting out in practice, the benefits accruing therefrom are mutual. The physician is enabled to begin his practice on a solid foundation and pay off the debts which he has acquired for his medical education; the community at the same time will benefit from the vitality, energy and fresh knowledge of the young practitioner.

The advantages of such circumstances, however, can easily be inverted to become detrimental. If the young practitioner remains too long in isolation, hesitating to give up a relatively assured income—and he is entitled to security like any one else—he gradually and inevitably falls into a rut. It becomes more and more difficult for him, particularly when the demands of his patients consume so much of his time, to maintain and establish contacts with other members of his profession and to keep up, by reading and attending meetings, with the newer developments in medicine or to obtain more of the broad experience available in the larger areas or metropolitan centers. It takes a man with an unusual amount of willpower, determination and ambition to ward off the constrictions that are imposed on him by his isolation and the nature of the work he is doing.

To the physicians who practice in the coal mining communities, certain provisions in the Krug and Lewis Agreement have been highly disturbing. These are the provisions under section 4 dealing with a "health and welfare program." Under this program, two funds are to be set up, one of which is "a medical and hospital fund." I want to add at this point that the survey which we are conducting has only an indirect relationship to these funds.

There has been a lot of confusion about those funds, so I might take a moment to clarify it. You have heard that, under the Krug and Lewis Agreement, the first is Fund A in which the money comes from the 5¢ a ton royalty from coal. That is to go for retirement benefits and welfare, which have certain limitations defined, and yet to my mind need further definitions. The trusteeship for the control of that money accruing from the 5¢ a ton is composed of one trustee appointed from the government, one from the United Mine Workers of America and two elected members.

The other medical fund is for medical care and hospitalization. The money comes from the pay envelop deductions voluntarily, from the miner. That fund is to be administered by a trusteeship set up by the United Mine Workers of America. At the present time, the check-off money is collected by the operators and paid to physicians or hospitals in the various systems.

Then there is meant to be a correlation or implementation of the two funds and that is, as any mind can see, where trouble

may arise. I do not know exactly how they were worked out. I might say that the many millions of dollars that have accrued from Fund A already, from the 5¢ a ton deduction, has been held in escrow in the First National Bank in New York under the custodianship of the Paymaster General of the Navy.

The medical fund which is to be administered by trustees appointed by the President of the United Mine Workers of America is to be accumulated from wage deductions of mine workers and is to be used for medical, hospital and related purposes "at the discretion of the trustees of the fund." Collections for this fund have not yet started, but what changes in the present system of medical practice will follow its establishment, no one, except possibly a few persons inside the United Mine Workers of America organization, can foretell. Whether the trustees will eliminate the direct payment of the "check off" to physicians; whether the money collected from the workers will go into a common fund to be spent on a local, regional or national basis, or whether the trustees will attempt to obtain medical services on a salary basis or on a fee for service basis is unknown. The mine physicians, I understand, are not so much concerned about their economic security as they are in the maintenance of their professional status. That is the concern of all medical men, because the establishment of this particular medical fund may be the precedent for similar funds in other industries. What changes this new departure, which may inject third parties between physicians and patients, will tend to bring about in medical practice, no one knows; but it is evident that the American Medical Association has been handed a problem which it cannot and is not overlooking. The views which organized medicine takes in handling such problems will help to fashion the pattern that is eventually evolved. Organized medicine, as I have said, must dissipate any emotionalism that beclouds sound reasoning and must assume leadership in the formulation and establishment of reasonable and practical programs that will benefit the people.

The ideals of the medical profession are as strong today as they were about twenty-four centuries ago when they were promulgated by Hippocrates. It is a tribute to the men of the medical profession that, on the whole, there has been so little straying from the path which the profession has marked for itself. The road ahead, however, is marked by pitfalls and obstacles. We must assure ourselves first that these are real obstructions and then remove them efficaciously, so that we may continue to move forward and serve humanity, for what is in the best interests of the people is best for the profession of medicine.

Committee of the Whole

On motion of Dr. Edwin S. Hamilton, Illinois, seconded by several, the House resolved itself into a Committee of the Whole for the consideration of the report of the Special Committee on Executive Session for Consideration of the Rich Report, with Dr. Hamilton as chairman.

Executive Session—Tuesday Afternoon

The House reconvened in Executive Session at 3:30 p. m., with the Speaker, Dr. Roy W. Fouts, presiding.

Report of Committee of the Whole

On motion of Dr. Edwin S. Hamilton, Chairman, seconded by several and carried, the report of the Committee of the Whole, which recommended adoption of the following portions of the report of the Special Committee on Executive Session for Consideration of the Rich Report, was adopted:

In opening a detailed discussion of the many recommendations involved in this report, your committee wishes to dwell first on the conclusion reached by Mr. Rich—offered, not as a recommendation but rather as an accepted mechanism for the activities of the American Medical Association—as stated in the last paragraph on page 1 of his report, "To separate distinctly the functions of scientific interpretation, medical economics and social medicine, and the direction of public relations." While recognizing the advantage of creating such several agencies, whether as committees, bureaus or councils, yet because of the overlapping and intermingling of the interests and activities of these several departments and for the sake of clearcut, now confusing, public relations and for the proper preservation, at all times, of the well considered professional viewpoint, it would seem essential to designate one officer or one small committee or council with authority to act in the capacity of interdepartmental supervisorship.

I. Proceeding to a detailed consideration of specific recommendation, your committee approves of recommendations no. 1 and no. 2 on page 2 of the Rich Report, reading as follows:

> 1. We *Recommend*, therefore, that the Association seek every possible opportunity and means to describe and dramatize the progress of scientific medicine, what it promises to mean to mankind, and especially, all that the Association has done and is doing to advance this progress.
>
> 2. We *Recommend Further* that this vital assignment be entrusted to the Editor of THE JOURNAL who, in our judgment, is on all counts best equipped to present this story with a degree of authority and with a brilliance which will appeal to the general public.

The suggestion is made, however, that in addition to a presentation of the purely scientific accomplishments of the profession the story of the development of organized medicine in America be made known. The approaching Centennial of the American Medical Association affords an excellent opportunity for acquainting the public with our story. This might well be accomplished by a series of articles published in Hygeia and in other periodicals depicting, chronologically, the more dramatic and significant steps in the history of the development of organized medicine in America, such as is now appearing in THE JOURNAL OF THE AMERICAL MEDICAL ASSOCIATION. Beginning with the Medical Society of New Jersey, organized in 1766 for the purpose of improving the practice of medicine and inspired by a need for bettering the care of disabled veterans of the French and Indian War, and so all down the line, in the formation of city, county, state and national organizations, the motivating factors have been betterment in the quality of medicine and the welfare and protection of the public. These facts well speak for themselves without elaboration.

II. Your committee cannot agree fully with the preamble on page 3 of the Rich Report leading up to recommendations concerning Hygeia. During war years, the circulation of this periodical was largely determined by the amount of paper available. Its circulation could have been doubled at any time. Your committee is somewhat at a loss to understand the implications in the criticism of the commercial methods of promotion used. It is fully in accord with the proposition that Hygeia should be vitalized into the most powerful medium of approach to the reading public. It should not only carry pertinent scientific facts suitable for public consumption but should also aquaint the laity with the "Doctor Story" and present the profession's side of all controversial matters. This magazine would afford an excellent medium for the presentation of the history of the development of organized medicine alluded to in the foregoing section. With these thoughts in mind, we approve of recommendation no. 3 on page 3 of the Rich Report, reading:

> 3. We *Recommend*, therefore, that the editor be requested to devote particular attention to the urgent task of vitalizing *Hygeia*, and that he be authorized to obtain a fully competent managing editor with adequate editorial and art assistants.

This committee does not approve of recommendation no. 4 on page 3 of the Rich Report, which reads:

> 4. We *Recommend Further* that the editor-in-chief be requested, each year, to reserve exclusively for *Hygeia* an appropriate number of his most vivid and popular articles.

III. In common with Mr. Rich, your committee recognizes the fact that the average busy physician may be a poor business man and perhaps an irregular economist, but he has done and is doing a splendid job for the American people. One advantage which the practicing physician has over the trained economic theorist is a first hand knowledge of people of all classes and a sympathetic understanding of their needs, both medical and socioeconomic. Our Bureau of Medical Economics up to the present has confined itself to the study and analysis of every conceivable phase of medical economics. It should continue to

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be headed by the best trained man available. With this suggestion your committee approves recommendation no. 5 on page 4 of the Rich Report which reads as follows:

> 5. We *Recommend* that in order to obtain a truly superior person of the highest caliber, he be offered not only direction of the Bureau but also responsibility for procuring and developing the material for a Department of Medical Economics and Social Medicine in THE JOURNAL and in *Hygeia*.

IV. With regard to the section on "Diverse Opinion," we are fully in accord with the proposition that all responsible minority groups should be afforded the privilege of giving public expression of their views. However, every member has had experience in his own county or state organization with the crack pot chronic objector, the mouth piece of no group, who makes a persistent nuisance of himself. The Editor should be permitted the use of his discretion in denying publicity to such persons. Your committee feels that diverse economic opinions should be limited to THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION and other journals for professional reading and not put in lay publications. With these exceptions, your committee approves of recommendation no. 6 on page 5 of the Rich Report, which reads:

> 6. We *Recommend*, therefore, that the economist appointed to the position mentioned shall give opportunity in his department of THE JOURNAL and of *Hygeia* for the expression of diverse viewpoints. This, we are convinced, will create a dynamic atmosphere which will go far to arouse the active interest of the many doctors whose lethargy has rightly been a matter of grave concern.

V. Your committee is fully in accord with the need of a more positive type of public relations program. It likewise recognizes the advantage of trained directorship in the development of such a program and it understands that a director has been appointed.

From past experience your committee knows that publicity experts, in their enthusiasm to attract the attention of the reading public, have been known to produce misleading headlines and tincture truth with fiction to the detriment of the dignity of the profession. With no intent to hamper this new officer, your committee nevertheless urges that all publicity and all projects promulgated by him be approved by the General Manager before published or undertaken. If this stipulation is made mandatory, your committee approves recommendations nos. 7 and 8, page 6 of the Rich Report which read:

> 7. We *Recommend*, therefore, that the General Manager be authorized to appoint an Executive Assistant in charge of coordinating and servicing the public relations activities of all officers, councils, bureaus, divisions and departments of the Association.
>
> 8. We *Recommend* further that this new appointee have the responsibility of developing, with the full support of the Board, ways and means of greatly broadening the system of interpretation of the Association to the public on matters other than scientific medicine.

Three Essential Goals: On pages 8 and 9 of the Rich Report, the subject of Three Essential Goals provides no points of difference. This committee is in agreement with the views expressed, which read as follows:

> Viewing the field of medical economics and social medicine from a public relations standpoint, there are three basic tasks—three essential goals, they might better be called. Each must be held constantly in mind by the Association.
>
> Find the Truth: The first of these goals is for the Association to convince the public that it is seeking the truth as honestly in the economic and social aspects of medicine as it is in the scientific. And it must recognize that in these fields, to which it is less accustomed, there is as yet no proven truth. To put it otherwise, truth here, as in medicine, must be found in the clinic. But here the clinic is the public. And in this clinic the patients are not prostrate—they are active, vigorous and articulate. And they have various views about what they want to have happen to them when they do become prostrate, as they know they will sooner or later.
>
> Moreover it must constantly be remembered that patients in this clinic *control* the public relations of the American Medical Association. Neither the American Medical Association itself nor the wisest public relations counsel can control its public relations. But confident reliance may be placed in a most substantial, even remarkable, improvement in its public relations if the American Medical Association will give a fair hearing week in and week out, year in and year out, to those who with sincerity and intelligence are inclined to other viewpoints or who believe there are neglected developments and issues which need attention. Only by full discussion can the right answers be found.
>
> Put the People First: Study alone will not suffice. The second essential goal is to show the public that the American Medical Association is actually following up the truth which it finds by doing everything in its power to bring medical care to all the people. As one nationally known public relations practitioner put it, the American Medical Association must prove "that it is out fighting for medical care that the public can afford."
>
> This means that the Association must deal first and foremost with the needs of the public; second, with the welfare of the physician. In other words, its actions must be the organized embodiment of the first statement in the "Principles of Medical Ethics":
>
> "A profession has for its prime object the service it can render to humanity; reward or financial gain should be a subordinate consideration. The practice of medicine is a profession. In choosing this profession an individual assumes an obligation to conduct himself in accordance with its ideals."
>
> Become Adequate: Finally the performance of the Association must be adequate. As one writer has recently said with reference to the National Health Program adopted Feb. 14, 1946, "The American Medical Association has submitted itself to the test of accomplishment."

National Physicians Committee for the Extension of Medical Service: This committee recognized: 1. That each member of the American Medical Association is primarily a citizen with the inalienable right to join any organization. 2. That the House of Delegates has on two previous occasions endorsed and commended the work of the National Physicians Committee for the Extension of Medical Service. 3. In line with the new program in the process of accomplishment, this committee feels that the American Medical Association should and must do its own public relations and legislative work. This implies no lack of appreciation of similar work done and to be done by other organizations devoted to the best interests of the public and of organized medicine. 4. In view of the controversial character of the Rich Report and in view of lack of documentary evidence relating to the National Physicians Committee for the Extension of Medical Service, this committee recommends further study of this portion of the report.

Lay Participation in Voluntary Plans: In many of the plans, there is lay participation. Few, if any, have total medical control and as long as we are providing medical service, control should be vested in the hands of the physicians. With that in view, this committee approves recommendation no. 10 on page 12 of the Rich Report, which reads:

> 10. We *Recommend*, therefore, that the relationship of lay participation to the successful development and operation of voluntary health insurance plans be the subject of objective study and that, unless there shall prove to be conclusive evidence to the contrary, the present requirements for total medical control be revised promptly.

In the Sherburne resolution, reference is made to the Council on Medical Service and Public Relations. Since these two functions are now divided, this recommendation should apply to the duties of the Executive Assistant to the General Manager.

Provided that the work of the Executive Assistant first meets with the approval of the General Manager, your committee approves of recommendation no 11, page 15 of the Rich Report, which reads:

> 11. We *Recommend*, therefore, that the Secretary and General Manager be requested to implement as fully as possible the resolution on modern medical public relations introduced by Dr. C. C. Sherburne of Ohio, and adopted by the House of Delegates last December. In doing so, however, the work should be performed through the Executive Assistant called for above.

The committee approves parts 1 and 2 of recommendation no. 12 on page 16 of the Rich Report, which read:

> 12. We *Recommend*, therefore,
>
> 1. That each council and bureau be requested to identify in its field all legitimate organizations having cognate interests; then to develop in cooperation with the Executive Assistant, for Board approval, specific plans for establishing practical cooperative relationships with them.
>
> 2. That the execution of the approved programs be under the guidance of the General Manager's Executive Assistant.

BUREAU OF HEALTH EDUCATION

Your committee has studied with care that portion of the Rich Report pertaining to the Bureau of Health Education. It agrees with Rich Associates that here the Association possesses an instrumentality of great potential importance in public relations. While the achievements of this Bureau in many respects has been impressive, many helpful suggestions have been forthcoming. Your committee feels that this activity should be stimulated and its good work furthered. With this in mind, adequate personnel should be supplied and suitable junior executives created to assume responsibilities for the various phases of work. This has already been accomplished in the appointment of added personnel of high caliber (Dr. Smiley and Mr. Hein).

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The report points out that the work of the Bureau of Health Education falls in two distinct and important parts: one is the health education of the public and the other is the school program. Each is equally important and neither can be neglected by the American Medical Association. Each should have the benefit of strong lay counsel. This report recommends that two advisory councils be appointed by the Board of Trustees to deal, respectively, with popular health programs and with school health programs. While your committee feels that definite responsibility for each of these two activities should be delegated to certain executives of the Bureau of Health Education, it questions the wisdom of more councils and greater bureaus. Your committee feels that the Director of the Bureau of Health Education should be responsible for the activities of this Bureau to the Board of Trustees. Policies of the Bureau are to be determined by the House of Delegates while the Board of Trustees acts as interim agent. Further cooperation with various educational bodies in order to cultivate the school health program is to be stimulated. This has been done in the past by the Bureau of Health Education.

With the substitution of the word "committees" for the word "councils," this committee approves recommendation no. 13 on page 18, of the Rich Report, reading:

13. We *Recommend*, therefore, that taking into consideration nominations by the Director of the Bureau and the Executive Assistant to the General Manager, the Board of Trustees appoint two advisory councils dealing respectively with school health programs and with popular health programs.

This committee approves recommendation no. 14 on page 19 of the Rich Report, which reads:

14. We *Recommend*, therefore:

1. The establishment of a "Health and School Section" of the Bureau.
2. The appointment of an Assistant Director to be in charge of this section.

Good progress has been made in the field of popular health education by our Association in the past; fertile fields lie ahead. Through various publications, releases and radio presentations immeasurable good will and education have been disseminated, a truly great work of public relations which could not but react favorably for our profession. Your committee recommends continued expansion in this field of activity.

With the addition of the words "Associate or" in front of Assistant Director, the committee approves recommendation no. 15 on page 20 of the Rich Report, reading:

15. We *Recommend*, therefore, the appointment of an Assistant Director to be in charge of Liaison with voluntary professional and lay organizations concerned with popular (as distinguished from school) health education.

Your committee feels that great good in health education can be accomplished through medical societies and voluntary medical service plans. Good progress has already been made in the larger medical societies, especially where paid executive secretaries are available. These avenues should be utilized further and the good start already made continued. The voluntary service plans offer an exceptional opportunity to contact the public and this means should be developed to the utmost. Adequate liaison with both the medical societies and voluntary medical service plans should be maintained and the Bureau should be ready to serve as voluntary consultant in the development and execution of their health education programs.

When the Bureau of Health Education develops to the point where the necessity for a field secretary is shown, the committee feels that recommendation no. 16 on page 21 of the Rich Report should be approved. This recommendation reads:

16. We *Recommend* the appointment of a field secretary to serve the voluntary plans as a consultant in the development and execution of their health education program.

The publications of the Bureau of Health Education were reviewed and suggestions were forthcoming. They were criticized from the standpoint of (1) out of date material; (2) extent of treatment; (3) method of treatment, and (4) format and make-up. It was suggested that the present out of date material be reviewed and if there is still a need for a particular publication it should be brought up to date, or if the need no longer exists the stock of such articles be scrapped. In this your committee thoroughly agrees; it cannot miss this opportunity to say that many articles which today are live material, tomorrow may be obsolete. This can best be exemplified by the rapid change brought about in treatment by introduction of the sulfa drugs and penicillin. Nevertheless, these suggestions should receive our earnest consideration. Your committee believes all publications should be periodically brought up to date, and when an article is found out of date it should be withdrawn from distribution. This is especially true of those containing inadequate material or those which by reason of format, illustrations and makeup are unattractive.

In reference to recommendation no. 17, page 22 of the Rich Report, your committee approves part 1 with the substitution of the words "withdrawn from distribution" for "scrapped."

Your committee approves part 2 of the recommendation with the addition that "a new list of classified health publications be prepared."

In reference to part 3 of the recommendation, your committee finds that this has already been done and therefore recommends this portion of the report.

In reference to part 4, your committee finds that this is already in force and, therefore, approves this portion of the recommendation. Recommendation no. 17, pages 22 and 23 of the Rich Report reads:

17. We *Recommend*, therefore, that:

1. The present stock of out-of-date pamphlets be immediately scrapped.
2. No further use be made of the present list of "Health Publications of the Bureau."
3. The Bureau be required to have each of its publications periodically reexamined as to scientific content by competent authorities.
4. Whenever a publication is found to be out of date it be withdrawn from distribution, and be rewritten if the subject is still important.

Your committee would like to suggest the great possibility for public relations through the greater utilization of the constituent state and component county societies. These societies are on the firing line, so to speak, and through them a great distribution of literature to the public can be accomplished.

Your committee approves recommendation no. 18 on page 23 of the Rich Report, which reads:

18. We *Recommend*, therefore, that to insure adequacy of treatment the indicated pamphlets be rewritten in consultation with a competent lay writer.

The committee feels that the need suggested in recommendation no. 19, page 24 of the Rich Report, is one calling for further investigation before approval. This recommendation reads:

19. We *Find Need* for popular editing and professional styling.

Circulation: Reverting to the subject of the circulation of the Bureau publications

We *Find Need* for (1) a wholly new catalogue or advertising leaflet, (2) separate advertising sheets for various groups of publications, (3) development of depository and distribution arrangements with state and county societies and (4) overall distribution and sale promotion by appropriate adaptations of proven business methods.

The report recognized the need and broadening influence of radio programs (recommendation no. 20, page 26 of the Rich Report) and the Committee concurs in the extent to which the recognition should be used in further study. Recommendation no. 20 reads:

20. We *Find Need* for competent assistance to aid in conceiving program ideas, procure and work with the best available script writers wherever they may be, obtain network sustaining time and inclusion in commercial time, supervise production, and advise state and county societies regarding the procurement and use of local time.

COUNCIL ON MEDICAL SERVICE

The name of this Council was changed at the San Francisco Session and its new duties clearly outlined by changes in the By-Laws.

In reference to recommendation no. 21 on page 28, part 1, of the Rich Report the change in the name of the council is already an accomplished fact, according to the By-Laws, under the name of Council on Medical Service and, therefore, the Committee approves the recommendation.

Regional Conference and Unorganized States. One of the functions of this Council, Chapter IX, Section 4, By-Laws, shall be "(6) to develop and assist committees on medical service and public relations originating within the constituent associations and component societies of the American Medical Association."

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Conferences may be held on invitations from constituent associations or component societies. The composition of these conferences should be determined at the local level. The American Medical Association should encourage these conferences and cooperate with the local constituent association and component societies.

The News Letter and Present Deficiencies. Your committee suggests that the excellent News Letter of this Council be further improved as facilities permit and that it be given wider dissemination. It suggests further that the Council study and recommend other facilities for transmitting news to the profession and general public.

BUREAU OF MEDICAL ECONOMICS

Your committee sees no advantage to be gained by the proposed change in the name of this Bureau. This Bureau should, in our opinion, concern itself with the science of economics in its broadest sense with particular reference to the practice of medicine and public health. Its findings will, of course, be available to all.

BUREAU OF LEGAL MEDICINE AND LEGISLATION

In the opinion of your committee "it would be most unwise for the Association to become as 'legislation conscious' as Mr. Rich would have it do. It is an organization with scientific objectives and it should remain so."

The committee disapproves of recommendation no. 22, page 33, in the Rich Report, and in its stead recommends that the Bureau of Legal Medicine and Legislation be prepared to assist in the development of legislation in accordance with principles established by the House of Delegates. Recommendation no. 22 reads:

> 22. We *Recommend*, therefore, that the Bureau of Legal Medicine and Legislation be requested and be enabled systematically to prepare legislation based on the findings of the Bureau of Medical Economics and Social Medicine and on the experience of the Council for the Extension of Medical Care; this draft legislation to be submitted to the House of Delegates for its action.

The committee concurs in the need for the availability of virtually the same services as those mentioned for the Bureau of Medical Economics. Recommendation no. 23, page 34 of the Rich Report, reads:

> 23. We therefore *Find Need* for the availability of virtually the same services as those mentioned for the Bureau of Medical Economics and Social Medicine.

COUNCIL ON INDUSTRIAL HEALTH

Your committee is in agreement with the general recommendation concerning this council. It feels that common public relations with this council and other related councils and bureaus should be stressed. More attention should be paid to industrial and consumer groups in view of the recent developments in connection with the United Mine Workers Health Fund. This will obviously place extra work on this council necessitating additional experienced help. Finally, it believes that the work of this council should be commended and that this council should be implemented with sufficient funds and staff to broaden its work with labor, management and consumer groups.

The committee approves recommendation no. 24 on page 35 of the Rich Report reading:

> 24. We *Recommend* that in view of the great public relations contributions which can be made by this Council every possible encouragement and facility be given to the conduct of its work.

The committee concurs in the findings that there should be services supplied similar to those required by the Council on Medical Service, contained in recommendation no. 25, page 35 of the Rich Report, which reads:

> 25. And we *Find Need* for supplying services similar to those required by the Council for the Extension of Medical Care.

SCIENTIFIC COUNCILS AND BUREAUS

Each of the scientific councils and bureaus has an opportunity to improve our public relations. On account of the diversified activities and interests of the councils and the overlapping work of some of them, your committee would like to emphasize again the absolute necessity of having an executive assistant to the General Manager responsible for the public relations and publicity of all of these agencies.

FUNDAMENTAL PRINCIPLES

In any large organization, it is a fundamental principle that coordination of all activities of such an organization is absolutely essential. Your committee recommends the appointment of a capable and experienced executive assistant to the General Manager whose duty it shall be to coordinate and service all public relations activities of the Association. To do this, the Executive Assistant must be in attendance or have an experienced reporter in attendance at all important board, council and committee meetings and thereby acquire and coordinate the information necessary to carry out the duties of his office.

The committee concurs in the suggestions of this report in reference to *A*, *B* and *C* of recommendation no. 26, page 37 of the Rich Report, which read:

> Fundamental Principles: To build up desirable public relations there are three essentials for the American Medical Association as for any other organization: positive and constructive policies; effective, adequate and coordinated action; balanced and efficient promotional and interpretive facilities.
>
> It will be recalled that the recommendation on page 6, approved by the Executive Committee, calls for an Executive Assistant to the General Manager charged with *coordinating* and *servicing* all public relations activities of the Association.
>
> He must, therefore:
>
> A. Have the right to attend all Board, Council and Committee meetings and, when he considers it necessary, to express opinion regarding public relations aspects of their deliberations.
>
> B. Have means of receiving, and channels for disseminating, intelligence calculated to achieve coordination of all actions that hold public relations implications.
>
> C. Have direct responsibility and adequate provisions for the promotional and interpretive (publicity) assistants recommended below.

The committee approves recommendation no. 27, page 38 of the Rich Report, with the understanding that the attendance of the Executive Assistant or his reporter be subject to the approval of the General Manager. Recommendation no. 27 reads:

> 27. We *Recommend*, therefore, that the Board of Trustees at its next meeting take the indicated action with respect to its own meetings and formally request all councils and committees to do likewise.

Requirement B of this report necessitates that the Executive Assistant be informed through the General Manager of the problems that arise in the constituent state associations so that he can more properly formulate a positive program concerning the problems of extension of medical care and health legislation. Finally, the recommendation concerning a "House Organ" should be implemented, which would enable the American Medical Association to present to its membership the full picture of the ever changing problems of medical care both pro and con, and that in addition authoritative points of view on current stands of the American Medical Association should be published for the benefit of constituent state medical associations. The committee, therefore, approves recommendation no. 28 on page 39 of the Rich Report with the foregoing changes. That recommendation reads:

> 28. We *Recommend*, therefore
>
> 1. That a national "house organ" be established.
>
> 2. That the Executive Assistant be enabled to engage a competent reporter to handle this publication under his supervision.
>
> 3. That the Executive Assistant be responsible for procuring and developing the material for the "Organization Section" in THE JOURNAL and for notes of this character in *Hygeia*.

PUBLICITY

In reference to recommendation no. 29 on page 40 of the Rich Report this committee approves. That recommendation reads:

> 29. We *Recommend*, therefore,
>
> 1. That the present editor of the clip sheet be transferred to the office of the Executive Assistant with the understanding however, that his writing on scientific subjects and his contacts with writers on scientific matters be subject to the approval of the Editor of THE JOURNAL.
>
> 2. That the present "Bureau of Public Relations" be discontinued.

PAMPHLET PRODUCTION

The committee approves recommendation no. 30 page 40 of the Rich Report reading:

> 30. We *Recommend*, therefore, that the Executive Assistant be enabled to engage a competent person to conduct a centralized service of pamphlet production.

RADIO

The committee approves recommendation no. 31, page 41 of the Rich Report that provision be made for a junior radio specialist on the staff, backed by highly experienced professional counsel, if, after study, it is justified by need and cost. Recommendation no. 31 reads:

> 31. We *Recommend*, therefore, that provision be made for a junior radio specialist on the staff, backed by highly experienced professional counsel.

VISUAL TECHNICS

Your committee is certain that close cooperation with the National Education Association is and can continue to be a powerful adjunct in public medical education.

The committee does not approve of recommendation no. 32 in page 42 as it is written, but substitutes "We recommend, therefore, that all possible uses of visual technics be utilized backed by the advice of professional counsel."

PROMOTION

In reference to recommendation no. 33, on page 43 of the Rich Report, the committee approves, subject to cost and demonstrated need, the recommendation reading:

> 32. We *Recommend*, therefore, that the Executive Assistant be enabled to engage a competent promotional specialist.

SPEAKER'S BUREAU

In reference to the Speaker's Bureau on page 43, recommendation no. 34, the committee recommends that the Speaker's Bureau should be not only initiated but activated and utilized to its fullest capacity. That recommendation reads:

> 34. Speaker's Bureau: Since the need for a Speaker's Bureau has already been seen by the Trustees, and since we fully concur, no recommendation to initiate such a facility is needed. We ought to express our judgment, however, that this should never become a mere group of itinerant professional speakers. It should be essentially a national service bureau for the needs of national bodies and for the speaker's services which, it is to be hoped, will be operated by a growing number of constituent societies. It should actively identify up-to-the-minte speakers on medical topics and find appropriate places for them to speak.

CONTINUING COUNSEL

The committee recommends, therefore, that competent counsel be retained as advisor to the Executive Assistant and that all matters pertaining to public relations and publicity emanating from the counsel should be cleared through the office of the General Manager. Your committee fully recommends that until the program is established and evaluated no long term contracts be entered into with reference to the employment of counsel or other lay personnel recommended by this report.

APPENDIX A OF THE RICH REPORT

This material involves editorial, art, scientific, management and publicity departments. In view of the steps already taken to reorganize and fortify some of these departments and the steps taken to inaugurate a new public relations department, your committee does not feel justified in doing more than recommending that these suggestions be called to the attention of proper executives to take such steps as they find necessary.

The committee approves appendix A of the Rich Report which evaluates the Health Publications of the American Medical Association.

APPENDIX B OF THE RICH REPORT

Your committee has read with interest the criticism of this work, and again recommends that these criticisms be called to the attention of the proper authorities for such action as is necessary.

The committee approves appendix B of the Rich Report evaluating transcriptions submitted for audition.

APPENDIX C OF THE RICH REPORT

This is a field of activity which is so controversial and so costly, and one in which competition with many other types of program is so keen, that this committee recommends that this whole problem needs further investigation before committing the American Medical Association to excessive expenditures.

The committee approves appendix C of the Rich Report offering suggestions regarding expanded use of the radio.

In conclusion your committee wishes to state that the complete implementation of this report will cost an estimated minimum of $300,000 annually, and feels that this delay of six months before taking final action on the Rich Report was warranted. However, the work of this committee has been, to a large extent, rendered superfluous by the fact that the Board of Trustees initiated some of the recommendations of the Rich Report prior to the Rich investigation and many of the recommendations prior to the receipt of this committee's report for final action by the House of Delegates.

Supplementary Report of the Judicial Council

Dr. E. R. Cunniffe, Chairman, presented the following supplementary report of the Judicial Council, which was referred to the Reference Committee on Miscellaneous Business:

Report of Dr. A. C. Ivy.—This supplementary report concerns the report made by Dr. A. C. Ivy, who was sent to Europe as representative of the United States Government to review the war crimes of a medical nature committed by the Germans, which report was referred to the Executive Committee of the Board of Trustees, which in turn referred the matter to the Judicial Council.

The Council finds that the experiments described in Dr. Ivy's report are absolutely opposed to the Principles of Medical Ethics of the American Medical Association and are to be condemned. In order to conform to the ethics of the American Medical Association, three requirements must be satisfied: (1) the voluntary consent of the person on whom the experiment is to be performed; (2) the danger of each experiment must be previously investigated by animal experimentation, and (3) the experiment must be performed under proper medical protection and management.

Report of Committee on Centennial Celebration of American Medical Association

Dr. E. R. Cunniffe, Chairman, presented the following report, which was referred to the Reference Committee on Miscellaneous Business:

At the request of the Board of Trustees, the Committee on Centennial Celebration submits this preliminary report. It is a progress report to inform you of the plans so far as they have been developed.

The celebration will begin on Saturday night, June 7, when the Board of Trustees will give a dinner to several hundred of the most prominent laymen in the various walks of life in the United States—those interested in science, officers of allied professions, the financial world, editors, the Commander of the American Legion and men of national repute. There will be three speakers at the banquet, one of whom has already accepted, and the committee is awaiting the answers to the other two invitations before announcing the names.

The next day, June 8, will be known as "Medical Sunday." At 11 o'clock in the Auditorium, Atlantic City, three clergymen will speak on the spiritual side of medicine. Their addresses will be broadcast over a nationwide hook-up. Each speaker will be allotted twenty minutes. The speakers who have accepted our invitation are Rabbi Joshua Liebman of Boston, Dr. Ralph Cooper Hutchison, President of Lafayette College, formerly president of Washington and Jefferson College, and Monsignor Fulton J. Shean of Catholic University, Washington, D. C.

It is hoped that the state associations will stimulate their component societies to urge all local clergymen to call attention to Medical Sunday and say a few words to their congregations about the services rendered by the medical profession during the past one hundred years.

On the following day, Monday June 9, the Board of Trustees will give a dinner to the House of Delegates and officers and members of the different councils of the Association. There will also be two motion pictures shown, one portraying the development of medical motion pictures and the other a picture being especially developed for this meeting by the March of Time.

On Tuesday night, June 10, the President will be installed according to the traditions of our Association and there will be entertainment both before and after the addresses of the newly installed President and the retiring President. The entertainment will be furnished by two artists reputed to be among the finest in the musical world.

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Wednesday night, June 11, is reserved for the President of the United States, who will be invited early in the spring. However, it is considered wise to advise the special societies and fraternities that they should hold their banquets on that evening, since the President, if speaking, will surely be received by an overflow audience.

On Thursday night, June 12, the President's Ball will be held as usual, with three receiving lines—the retiring President, the President and the President-Elect. There will be two well known orchestras to furnish the music.

As special guests to be present at the General Scientific Meetings, the committee has invited Dr. Jonathan M. Meakins of Montreal, Canada, Dr. Watson Jones of London, England, and Sir Howard Florey of London, England.

The committee is asking all foreign countries either to send or to authorize a representative for their country to be present at our session.

MONDAY, JUNE 9—2 P. M.

Presiding Officer: EDWARD L. BORTZ, Philadelphia

The Antihistamine Drugs. GEORGE L. WALDBOTT, Detroit.
Poliomyelitis. HART E. VAN RIPER, New York.
Significant Trends in Cancer Research.
STANLEY P. REIMANN, Philadelphia.
Cardiac Recovery. JONATHAN M. MEAKINS, Montreal, Canada.
Intermission.

MONDAY, JUNE 9—3:45 P. M.

Presiding Officer: HENRY R. VIETS, Boston

PANEL DISCUSSION ON THE MODERN MANAGEMENT OF HEART DISEASE

PAUL D. WHITE, Boston, Leader

Diet. WILLIAM BRIDGES, Boston.
Digitalis. HARRY GOLD, New York.
Diuretics. ARTHUR DE GRAFF, New York.
Quinidine. LOUIS KATZ, Chicago.
JONATHAN M. MEAKINS, Montreal, Canada
Question and Answer Period.

MONDAY, JUNE 9—5 P. M.

General Summary. PAUL D. WHITE, Boston.

TUESDAY, JUNE 10—9 A. M.

Presiding Officer: CLYDE L. CUMMER, Cleveland

The Obstructive Prostate. FRANK HINMAN, San Francisco.
Presentation. EDWARD A. STRECKER, Philadelphia.
Emergency Treatment of Vascular Occlusions.
EDGAR V. ALLEN, Rochester, Minn.
Fractures. WATSON JONES, London, England.
Intermission.

TUESDAY, JUNE 10—10:30 A. M.

Presiding Officer: CHARLES H. PHIFER, Chicago

PANEL DISCUSSION ON EMERGENCY SURGERY

R. ARNOLD GRISWOLD, Louisville, Ky., Leader

Head Injuries. GLENN SPURLING, Louisville, Ky.
Abdomen. HENRY H. KESSLER, Newark, N. J.
Chest. EDWARD P. CHURCHILL, Boston.
Extremities. STERLING BUNNELL, San Francisco.
WATSON JONES, London, England.
Question and Answer Period.

TUESDAY, JUNE 10—12 M.

General Summary. R. ARNOLD GRISWOLD, Louisville, Ky.

TUESDAY, JUNE 10—2 P. M.

Skin Problems of the Elderly.
Uterine Bleeding. NORMAN MILLER, Ann Arbor, Mich.
Radioactive Products in Medicine.
STAFFORD WARREN, Rochester, N. Y.
New Antibiotic Agents.
SIR HOWARD FLOREY, London, England.
Intermission.

TUESDAY, JUNE 10—3:45 P. M.

Presiding Officer: CLYDE L. CUMMER, Cleveland

PANEL DISCUSSION ON ANTIBIOTIC THERAPY

WESLEY W. SPINK, Minneapolis, Leader

Streptomycin. CHESTER S. KEEFER, Boston.
Chemotherapy in Surgery. JOHN LOCKWOOD, New York.
The Development of Bacterial Resistance to Antibiotics.
PHILIP MILLER, Chicago.
SIR HOWARD FLOREY, London, England
Question and Answer Period.

TUESDAY, JUNE 10—5 P. M.

General Summary. WESLEY W. SPINK, Minneapolis.

The section meetings will be held as usual and each section will invite one foreign guest who is an outstanding man in that specialty to be present and read a paper on some subject of his choice. Another speaker, a member of the section, has been or will be chosen to read a historical paper on the development of that specialty during the last one hundred years. These papers will be published later and will form a very inclusive history of these different specialties. As a matter of fact, since there is a Section on the General Practice of Medicine, the development of the entire medical field will be covered for this period.

Most, if not all, of the sections have selected a list of names of foreign guests and have submitted that list to the program committee with choices listed as first, second and third. The committee has followed their wishes in practically all cases, selecting the men to be invited according to the desire expressed by the officers of that section. In a few instances, in order to get a wider distribution of our foreign guests, the committee has recommended a second or third candidate. Men from England, Scotland, France, Germany, Sweden, Norway, Switzerland, Chile, Argentina and Mexico have been invited. The committee has received information that the Department of State would like to assist us in securing two noted German physicians who are not in sympathy with the Nazi cause. When these names are submitted by the State Department, the committee will select and recommend its choice to the Board of Trustees.

This program of the sections will, of course, be supplemented by the usual complete number of scientific papers, and the committee is certain that it will be the best scientific program ever offered to the Association in its hundred years and will well deserve its place on the program of the centennial celebration. The committee has also sent a request to the Postmaster General of the United States, asking that commemorative stamps be issued during the time of the session. This matter will be pursued on the return of the Postmaster General to Washington.

It is probably unnecessary to announce that the history of the American Medical Association, portions of which are being published in THE JOURNAL of the American Medical Association, will be completed and offered to the public at that time. It is needless to say anything in praise of this history, as a reading of it will certainly reveal its merit.

The committee would like to make known the exceedingly valuable assistance given to it by Dr. Edward L. Bortz, Chairman of the Council on Scientific Assembly, Dr. Morris Fishbein, Editor of THE JOURNAL, and Dr. George F. Lull, Secretary and General Manager of the American Medical Association, and the complete cooperation of the Board of Trustees.

Respectfully submitted,

EDWARD R. CUNNIFFE, Chairman.
THOMAS S. CULLEN.
WARREN F. DRAPER.
THOMAS P. MURDOCK.
WALTER F. DONALDSON.
WILLIAM J. CARRINGTON.

On motion of Dr. James R. Reuling Jr., New York, seconded by Dr. Burt R. Shurly, Section on Laryngology, Otology and Rhinology, and carried, the House rose from Executive Session.

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Tuesday Afternoon—Continued

The House at 3:45 p. m. reconvened in regular session with the Speaker, Dr. R. W. Fouts, presiding.

Supplementary Report of Council on Medical Service

Dr. E. J. McCormick, Chairman, presented the following supplementary report of the Council on Medical Service, which was referred to the Reference Committee on Medical Service:

The American Cancer Society has established regulations for the control of information services, detection centers, service programs and diagnostic and treatment clinics. The American Cancer Society's control over any of these is only in the distribution of funds with the exception of the information services. None of these agencies can be set up or operated without the approval of the local county medical societies.

This control by the county medical society pertains not only to permission to set them up but to everything in regard to their operation, staffing and economic control. The American Cancer Society itself will not own or operate any agency. The only other agency which will have such a part in any of them is the American College of Surgeons, which will be requested to inspect the detection centers from a purely professional standpoint to determine whether or not they are doing a satisfactory professional job. This will be done just as the American College of Surgeons now inspects diagnostic clinics and hospitals.

The regulations which have been drawn up have been approved by the Professional Advisory Committee of the American Cancer Society, on which there are representatives of the American Medical Association, and by the Council on Medical Service of the American Medical Association.

It is recommended that the House of Delegates give approval to this program.

Report of Reference Committee on Rules and Order of Business

Dr. Edward P. Flood, Chairman, presented the following report of the Reference Committee on Rules and Order of Business, which was adopted on motion of Dr. Flood, seconded by several and carried:

Resolution on Appointment of Reference Committees and Resolution on Referring all Business to Reference Committees: Your committee has had before it a resolution from the Colorado State Medical Society and one of similar purport from the Utah State Medical Association. These resolutions are on the reference of all business to reference committees and on the appointment of reference committees.

Your committee has carefully read the resolutions and also the Constitution and By-Laws governing the appointment of reference committees. The Constitution and By-Laws adequately covers the questions raised in these resolutions and obviously anticipates that reference committees would be composed of duly elected members of the House of Delegates as specified in article 5, section 2 of the Constitution and in chapter VII, section 1 and chapter X, section 1 of the By-Laws.

Because of the above stated facts, your reference committee recommends that no action be taken on these resolutions.

Respectfully submitted,
EDWARD P. FLOOD, Chairman.
JAMES P. KERBY.
MATHER P. PFEIFFENBERGER.
RICHARD D. SIMONTON.
WILLIAM D. STOVALL.

Report of Reference Committee on Medical Education

Dr. J. F. Hassig, Chairman, presented the following report, which was adopted on motion of Dr. Hassig, duly seconded and carried after discussion and amendment, and after a motion was lost to recommit to the committee one portion of the report:

1. Report of the Council on Medical Education and Hospitals: Your reference committee reviewed the report of the Council on Medical Education and Hospitals of the American Medical Association which was read to the House of Delegates. This report is primarily a presentation of activities of the council in the last months and contains no specific recommendations requiring action of the House or recommendations to the House from this reference committee.

2. Supplementary Report of the Council on Medical Education and Hospitals: The supplementary report of the Council on Medical Education and Hospitals to the House contains two items requiring action by the House:

A. Your reference committee recommends that the House adopt the proposal of the Council providing for changing the wording of the "Essentials of an Acceptable School for Clinical Laboratory Technicians" to read "Essentials of an Acceptable School of Medical Technologists." Your reference committee recommends that in conformity with this change in title of the document there be changes throughout the text whenever the term "clinical laboratory technician" occurs to read "medical technologist."

B. In its supplementary report to the House of Delegates the Council on Medical Education and Hospitals also presented a modified version of the existing "Essentials for Approved Examining Boards in Specialties." These essentials set forth the principles regarding the establishment of specialty boards seeking approval by the American Medical Association. Your reference committee finds that no basic changes in principle occur in the revised essentials. The major changes are largely by way of clarification and expansion of the existing rather abbreviated form in which these essentials have been stated. The modified essentials appear to the reference committee to be more fully explanatory and to be more useful whenever there is consideration of the establishment of a new specialty board.

3. Report of Joint Committee for the Coordination of Medical Activities: The activities of this committee, formerly known as the Committee on Postwar Medical Service, are made freely available through publication of minutes of meetings in THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. The formal report of this committee to the House is a brief summary of recent activities of this committee. Your reference committee wishes to commend the past work of this committee through the difficult war years and believes that its future activities will likewise be of great importance in the world of medicine.

4. Report of Council on Scientific Assembly: The report of the Council on Scientific Assembly deals largely with special activities planned for the Centennial Celebration session in Atlantic City next year. The details of these plans were not presented in the general outline provided. The report promises a stimulating and interesting program.

5. Resolution on Rich Report: This resolution does not appear to your reference committee to lie in the field of its responsibilities and your committee wishes to return the resolution to the House of Delegates without recommendation or comment.

6. Resolution on Closer Cooperation Between the Medical and Dental Professions: This resolution appears to your reference committee to be worthy of serious consideration and study by the Board of Trustees of the American Medical Association.

7. Resolution on Teaching of Preventive Medicine and Public Health: This resolution calls attention to a field of medicine whose importance is continually increasing. Your reference committee feels that the attention paid to this aspect of medical education by the Council on Medical Education and Hospitals might be even greater than in the past.

Your reference committee recommends that this resolution be referred to the Council on Medical Education and Hospitals with the recommendation that it be employed as the basis for either an independent study of the teaching in this field or a portion of a more comprehensive study in which not only this but all other aspects of medical education in our medical schools might be comprehensively surveyed.

8. Resolution on Intern and Resident Medical Training: It appears to your reference committee that this resolution deals with a problem of importance in the hospital education of medical school graduates.

Your reference committee is in full accord with the statements in this resolution to the effect that internships and residencies should be evaluated entirely on the basis of the educational content of the training program and not on that of the monetary returns to the house officer. Your reference committee is cognizant that the Council on Medical Education and Hospitals is aware that house officerships of relatively inferior quality may seek to attract medical graduates through offering relatively

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large stipends. Your reference committee and the Council are agreed concerning the undesirability of this practice.

Your reference committee recommends that this resolution be referred to the Council on Medical Education and Hospitals for study with the recommendation that the Council's evaluation of internships and residencies should take into account any attempts on the part of a hospital to seek to offset deficiencies in the educational programs by an indefensible offering of financial remuneration.

9 and 10. Resolutions on Establishment of General Practice Sections in Approved Hospitals and on Requirements for Approval of Hospitals: The Resolutions on Establishment of General Practice Sections in Approved Hospitals and that on Requirements for Approval of Hospitals were considered together by your committee. This problem was thoroughly discussed by several who attended the meeting of the reference committee, which recognizes the problem presented in safeguarding the provision of hospital facilities for qualified physicians. The committee believes that the aims of these two resolutions may be met by the adoption of a single resolution embodying the important features of both resolutions. As a substitute for the two resolutions mentioned your reference committee recommends the adoption of the following resolution, and requests that the American Medical Association send a copy to the American College of Surgeons, the American College of Physicians, the American Hospital Association, the Protestant Hospital Association, the Catholic Hospital Association and every hospital in the country:

Resolved, That hospitals should be encouraged to establish general practitioner services. Appointment to a general practice section shall be made by the hospital authorities on the merits and training of the physician. Such a general practice section shall not per se prevent approval of a hospital for the training of interns and for residencies. The criterion of whether a physician may be a member of a hospital staff should not be dependent on certification by the various specialty boards or membership in special societies.

11. Resolution on Establishment of Certifying Board to Determine Qualification for General Practice: There is a resolution calling for the appointment of "a committee consisting of five members to formulate and recommend a plan for the establishment of a certifying board to determine qualifications for general practice." The importance of the problem of the general practitioner is recognized by your committee. This was discussed at great length by the reference committee and by the many who attended the open meetings of the committee. Your reference committee believes that the mechanism for this should follow the lines of the Essentials for Approved Examining Boards in Specialties which specifies that the board should be composed of representatives of the national organizations of that specialty including the related section of the American Medical Association.

Since the American Medical Association now has an established Section on General Practice, it would appear to your committee that this body, rather than a committee of the House of Delegates, should initiate this work. Therefore, the reference committee recommends the adoption of the resolution to read as follows:

Resolved, That the Section on General Practice of Medicine of the American Medical Association be requested to give consideration to a plan for the establishment of a certifying board to determine the qualifications for general practice and that the section be requested to make at least a preliminary report to the House of Delegates in June at Atlantic City.

12. Resolution on Standards Required for Certification by the Specialty Boards: Your reference committee is not aware of any actions of the American boards tending "to make more difficult entry of ex-service men to the boards." All the boards allow credit toward eligibility to applicants for the board examinations for appropriate service carried out in the armed forces. It does not appear appropriate to this reference committee to recommend to the American boards that credit for military service should be allowed except when medical officers carry out work in the field in which certification is desired in institutions providing adequate facilities under the direction of physicians competent to provide acceptable training in the specialty. In the opinion of your reference committee the American boards have adopted an understanding and fair policy in this regard.

Your reference committee recommends that this resolution be not adopted by the House of Delegates.

13. Resolution on Change of Policy of American Specialty Boards: The Colorado State Medical Society presented a resolution that the House of Delegates of the American Medical Association request the Advisory Board for Medical Specialties and the several American specialty boards to review and reconsider their policies in relation to residencies and preceptorships in the light of the fact that certain of the American specialty boards have recently announced discontinuance of their former practice of according credit for preceptorships. Your reference committee notes that ten of the fifteen existing American boards in the various specialties now award training credit for some sort for training of certification applicants under qualified preceptors. These boards have had reasonably satisfactory experience with the training provided under such preceptorships. Other boards have not found this type of training to be uniformly satifactory in the training of candidates. Difficulties are especially likely to occur in the case of specialty boards in which large numbers of candidates are seeking certification. Certain of these boards have had unfortunate experiences with preceptorship programs. Incidents have been too numerous in which preceptors have apparently been more interested in securing assistance for themselves in their practices than in the education of the prospective specialist. In at least one of the boards not accepting preceptorship training it has been found that the performance of candidates in the certification examinations compares unfavorably with the performance of those trained in residencies. It would be of no service to candidates for certification to be lenient in the assessment of educational programs in the preparation for certification, if the following of such programs by the candidate results in failure at the board examination.

Your committee recommends that this resolution be not adopted.

Respectfully submitted,

J. F. HASSIG, Chairman.
A. W. ADSON.
LELAND S. MCKITTRICK.
ALFRED S. GIORDANO.
HENRY B. MULHOLLAND.

Report of Committee to Consider Revision of Constitution and By-Laws

A copy of the present Constitution and By-Laws and a copy of the proposed new By-Laws as prepared by the Committee to Consider Revision of the Constitution and By-Laws were distributed to each delegate and Dr. F. F. Borzell, Chairman, of the committee, read the explanatory introduction as follows:

The House of Delegates at its last session, on motion of Dr. Lowell S. Goin of California, authorized the appointment of a committee to consider revision of the Constitution and By-Laws. In obedience to this action this committee, appointed by your Speaker, begs to present a report of its deliberations to date.

It was evident at our initial review of the present By-Laws and because of certain recent actions taken by the House calling for more immediate action, that we should concentrate our first attention on the By-Laws, leaving revision of the Constitution for final consideration next June. This decision was also influenced by the fact that the By-Laws may be revised immediately at the session in which such revisions or amendments are presented, but constitutional revisions or amendments require publication and a year's delay before final action at an annual session.

The committee also considered it beyond its province to propose any changes which depart widely from the basic intent of the present By-Laws. The changes therefore recommended are mainly those of rewording, rephrasing, recodification and rearrangement. These were all found necessary in order to correct and improve a set of By-Laws which has become, by reason of amendments, rather incongruous and illogical in arrangement. The changes made are minor in substance and in no way materially alter the recorded actions of the House.

The committee would prefer to have the proposed revision read word for word except in those sections where the wording of the present By-Laws is unchanged. By this approach we can perhaps present the reasons for each change as it applies

to the part under consideration. Since the proposed revision poses a rearrangement of the parts as compared to the present By-Laws, it will be necessary for this House to act on the entire proposal at one time, subject to such modifications as it may see fit to make. In other words, the House must first express its approval of the revision in order to be prepared to revoke the present By-Laws and immediately adopt the revision.

It should be understood that the committee will, in accordance with the original motion, continue its deliberations on a revision of the Constitution and report at the next annual session.

Nothing in this proposed revision of the By-Laws involves any change in the Constitution.

Respectfully submitted,

FRANCIS F. BORZELL, Chairman.
LOUIS A. BUIE.
EDWIN S. HAMILTON.
JOSEPH D. McCARTHY.
STANLEY H. OSBORN.
B. E. PICKETT SR.
FLOYD F. WINSLOW.
T. V. McDAVITT, Secretary.

Dr. Borzell then suggested that the delegates study the proposed new By-Laws with certain indicated corrections for action on Wednesday.

Report of Reference Committee on Legislation and Public Relations

Dr. Charles H. Phifer, Chairman, presented the following report:

1. Resolution on Appointment of Surgeons General: Regarding the resolution presented with the report of the Committee on National Emergency Medical Service concerning the Surgeons General of the Army, Navy and Public Health Service and the Chief Medical Officer of the Veterans Administration, your Reference Committee suggests the substitution of the following resolutions:

Resolved, That the Secretary of the American Medical Association inform the President of the United States, the Secretary of War, the Secretary of the Navy and the Federal Security Administrator of the willingness of the American Medical Association, through a committee appointed for that purpose, to confer and cooperate with them in the important question of the selection of a Surgeon General for the Army, the Navy and the United States Public Health Service; be it further

Resolved, That the President of the United States, the Secretary of War, the Secretary of the Navy and the Federal Security Administrator be informed of the intensive study of war medicine which the association is conducting, and that the results of this study will be made available to them.

2. Resolution on Fellowship of Members of Permanent Corps of Veterans Administration: Your reference committee has considered this resolution and recognizes that it falls into two natural divisions: (1) the provision for representation of the Medical Department of the Veterans Administration in this House; (2) the admission to Fellowship of the members of the permanent corps of the administration without the payment of dues. Your committee considered these separately. In reference to the first division regarding the representation in the House of Delegates, your reference committee has very carefully weighed this question and its responsibilities. It is deeply conscious of the fact that the recent acts of Congress have established the Veterans Administration as a permanent medical corps of the United States, with General Hawley in charge of the program for medical care of the veterans, a position comparable to the Surgeon General of the Army, Navy and Public Health Service.

Therefore your committee recommends that the Veterans Administration be given representation in the House of Delegates and that the House proceed to take such steps as are necessary to accomplish this.

Regarding the second division as to Fellowship, your reference committee believes that due to the fact that the Veterans Administration has been authorized to care for 15 million veterans, the members of the permanent medical corps should receive the same consideration as that given to medical officers of the Army, Navy and Public Health Service with the understanding that Fellowship will continue only as long as they remain members of the permanent corps of the Veterans Administration. Such Fellows shall not receive THE JOURNAL or other publications of the American Medical Association except by their personal subscription. Your committee recommends the adoption of this section of the report.

3. Resolution on Sponsoring a National Conference of Officers of County Medical Societies: Your reference committee is most conscious of the high ideals that the proponents hope to obtain through the adoption of this resolution. Your committee is likewise most receptive to any constructive medical educational program. Your committee appreciates that this resolution involves numerous factors. It questions whether the program would not be more effective on a state or regional level rather than on a national level.

Because of the many facts that must be taken into consideration in reference to this resolution, your reference committee recommends that it be referred to the Board of Trustees for study and consideration as to its feasibility and value, with the request that the Board report its recommendations on this resolution to the House of Delegates in June 1947.

4. Resolution on Prohibition of Political Activity on Part of United States Public Health Service: Your reference committee shares the indignation expressed by the writer of this resolution but recommends as a more practical substitute the following resolution:

WHEREAS, The Surgeon General of the U. S. Public Health Service in a directive dated Dec. 10, 1945 and addressed to all officers of the Public Health Service, used the following language: "Every officer of the Public Health Service will wish to familiarize himself with the President's message [reference made to the message from the President to the Congress on Nov. 19, 1945] and will be guided by its provisions when making any public statement likely to be interpreted as representing the official views of the Public Health Service"; and

WHEREAS, It is the opinion of the House of Delegates of the American Medical Association that this is neither a proper activity for the Surgeon General of the Public Health Service nor in accord with American practice in prohibiting the free expression of opinion; be it

Resolved, That the House of Delegates of the American Medical Association express its complete disapproval of this conduct of the Surgeon General of the Public Health Service of the United States.

Respectfully submitted,

CHARLES H. PHIFER, Chairman.
THOMAS P. MURDOCK.
JOHN J. MASTERSON.
LOWELL S. GOIN.
EDWARD JELKS.

Dr. Phifer moved adoption of the first section of the report of the reference committee and the motion was duly seconded. After discussion, it was moved by Dr. James R. Reuling Jr., duly seconded and carried, that this section of the report of the reference committee be rereferred to it.

Dr. Phifer moved adoption of the second section of the report of the reference committee, and the motion was duly seconded. After discussion, Dr. G. Henry Mundt, Illinois, moved that this section of the report of the reference committee be rereferred to it, and the motion was regularly seconded and carried after discussion.

The third and fourth sections of the report of the reference committee were adopted, after discussion, on motions of Dr. Phifer, duly seconded and carried.

NEW BUSINESS

Resolutions on Veterans Administration Contracts

Dr. Herbert Bauckus, on behalf of the New York delegation, presented the following resolutions, which were referred to the Reference Committee on Miscellaneous Business:

WHEREAS, The Medical Society of the State of New York has learned that certain proposed contracts of the United States Veterans Administration with hospitals include as a part of the hospital service the practice of anesthesiology, pathology, radiology and physical therapy; and

WHEREAS, The rendition of these services constitutes the practice of medicine; therefore be it

Resolved, That the House of Delegates of the American Medical Association requests the U. S. Veterans Administration not to include the practice of anesthesiology, pathology, radiology and physical therapy as part of such contracts with hospitals; and, further, be it

Resolved, That the Secretary of the American Medical Association be requested to transmit a copy of this resolution to General Paul R. Hawley, Chief Medical Director, U. S. Veterans Administration.

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Resolution on Woman's Auxiliary

Dr. Thomas K. Lewis, Special Committee on Executive Session for Consideration of Rich Report, presented the following resolution, which was referred to the Reference Committee on Legislation and Public Relations:

WHEREAS, The Rich report, in survey, has shown the value of the Woman's Auxiliary; and

WHEREAS, The need for further expansion of the Woman's Auxiliary is proved; and

WHEREAS, We have repeatedly seen how effectively these groups may operate and how helpful they may be in public relations, especially demonstrated at the San Francisco Session in July, 1946; therefore be it

Resolved, That this House of Delegates recommend the extension of the development of the Woman's Auxiliary organizations, and that they be provided with a definite program.

On motion of Dr. William Weston, Section on Pediatrics, seconded by several, the House recessed at 6:10 p. m. until 9 a. m. Wednesday, Dec. 11.

(To be continued)

Washington Letter

(From a Special Correspondent)

Dec. 20, 1946.

Army-Navy Research Board Viewed as Forerunner of Merger

The Joint Research and Development Board in pioneering Army-Navy coordination in research is regarded as blazing a trail toward an ultimate merger of the services, if that is ever enacted by Congress. The board has obtained high caliber personnel by clearing them through such scientists as James Conant and Ernest Langmuir, and a unique rotation plan also assures competence. Full time staff members above the clerical level will remain only a year or so and will then be replaced by other topnotch scientific workers. The organization is also staffed by ranking scientists and technicians from the Army and Navy who will also be rotated. Key civilian personnel posts have been filled by top scientists and engineers, with influential committees headed by Nobel Prize winner E. E. Rabi, Karl Compton, Julius Stratton and others. Standards are so strict that after five months the staff is still far from complete. Dr. Vannevar Bush, the wartime chief of the Office of Research and Development, is chairman. The Joint Research and Development Board was formed by the Secretaries of War and Navy to coordinate the services' large research programs, and it was granted full power to eliminate duplication and allocate responsibility to each service in various fields of scientific investigation.

President Truman Appoints Atom Advisory Committee

President Truman has announced the appointment of a general advisory committee to advise the Atomic Energy Commission on scientific and technical matters. James B. Conant, president of Harvard University, will head the new group, and other members are: Lee A. Du Bridge, president, California Institute of Technology; Enrico Fermi, professor of physics, University of Chicago; J. R. Oppenheimer, wartime director, Los Alamos Laboratories of the Manhattan District; I. I. Rabi, professor of physics, Columbia University; Hartley Rowe, vice president, United Fruit Company; Glenn T. Seaborg, chief radiochemist, Manhattan District at the University of Chicago; Cyril Stanley Smith, director, University of Chicago's Institute of Metals, and Hood Worthington, chemical engineer, Du Pont de Nemours & Co.

Two Hundred Days of Combat Duty Reported As Limit of Human Endurance

Drs. John W. Appel and Gilbert W. Beebe of Philadelphia, Army psychiatrists, writing in the Bulletin of the U. S. Army Medical Department, report that two hundred days of combat duty, not necessarily continuous, is about the limit of human endurance. They claim there is no such thing as "getting used to combat."

Official Notes

A. M. A.-N. B. C. CENTENNIAL BROADCASTS

In celebration of the Centennial year of the American Medical Association, 1947, the twelfth annual series of the A. M. A.-N. B. C. dramatized broadcasts are devoted to features of medical progress in the United States during the hundred years of the existence of the American Medical Association.

For purposes of the broadcast, the United States is divided into twenty-five regions. These regions have been chosen with a view to grouping together states which have similar history and similar general characteristics, such as the four states of the Rocky Mountain region, the two groups of New England states, the Southeastern and the Central Southern groups.

One broadcast is devoted to medical progress in each of these regions, and the twenty-sixth and closing week will deal with the hundred years of the American Medical Association from a nationwide point of view.

The title for the series is "Doctors—Then and Now" and the theme is "A Century of Progress by American Medicine."

The dramatic scripts are written by William J. Murphy, veteran medical script writer responsible for most of the previous A. M. A.-N. B. C. series; production is directed by Norman Felton, director of the two preceding series; Joseph Gallicchio is again directing the N. B. C. orchestra. Arrangements with N. B. C. have been made through the office of Miss Judith Waller, public service director, central division, National Broadcasting Company.

The four dates for January with topics are as follows: January 4, South Carolina, Florida and Georgia, subject Crawford W. Long; the speaker, to be announced, will broadcast from station to be announced. January 11, New York, subject Stephen Smith; the speaker, Dr. William Hale, will broadcast from station WEAF, New York City. January 18, Louisiana; subject François Marie Prevost; the speaker, to be announced, will broadcast from station WSMB, New Orleans. January 25, Indiana; subject John S. Bobbs; the speaker, Dr. Floyd T. Romberger, will speak from station WIRE, Indianapolis.

Subsequent programs will be announced as soon as they are ready.

TELEVISION PROGRAMS

Additional programs scheduled for presentation over television station WBKB, Chicago, are as follows:

January 2. Rheumatic Heart Disease. Dr. Jesse W. Hofer.
January 16. Industrial medicine. Dr. J. H. Chivers, Dr. Harold R. Hennessy.
January 30. Child health clinics. Mrs. Virginia Shuler.

A program on plastic surgery, with Dr. Paul Greeley, was given for December 19, too late to announce.

Helpful cooperation on the part of the television station has resulted in continued improvement of the technic of health education through this medium. Acceptance of the basic principle that such education is an important and necessary service to the public is well established.

Coming Medical Meetings

Annual Congress on Medical Education and Licensure, Chicago, Palmer House, Feb. 10-11. Dr. Victor Johnson, 535 N. Dearborn St., Chicago 10, Secretary.

Central Surgical Association, Chicago, Feb. 20-22. Dr. Walter G. Maddock, 250 East Superior St., Chicago, Secretary.

Mid-South Postgraduate Medical Assembly, Memphis, Tenn., Feb. 11-14. Dr. Arthur F. Cooper, 1479 Carr Ave., Memphis, Secretary.

Pacific Coast Surgical Association, Seattle, Feb. 17-18; Victoria, B. C., Feb. 19-21. Dr. F. L. Reichert, Stanford University Hospital, San Francisco, Secretary.

Southeastern Allergy Association, Atlanta, Ga., Jan. 18-19. Dr. Katharine B. MacInnis, 1515 Bull St., Columbia 49, S. C., Secretary.

GOVERNMENT SERVICES

VETERANS ADMINISTRATION

SOME VETERANS MUST REPORT EARNINGS AT ONCE

Veterans in school or training under the G. I. Bill who have not reported their earnings to the Veterans Administration should report them immediately by letter or postcard without waiting to find an official report form. While these veterans have been temporarily suspended from subsistence allowance rolls, they can get back on the list and receive any money to which they are entitled merely by sending the necessary information to their regional office. The report to the regional office must include the veteran's earnings from productive labor during August, September and October, so that the Veterans Administration may adjust subsistence payments to meet the limitations set by Congress in public law 679, approved August 8. The law specifies that if a veteran's subsistence under the G. I. Bill and his earnings from productive labor total more than $175 a month (without dependents) or $200 (with dependents), his allowance must be reduced so that the combined total will not exceed those figures.

If the veteran's report shows that he is entitled to the full subsistence allowance, he will receive the entire sum due him since he was suspended. If his income from an employer is high enough to require a reduction in the allowance, he will receive the reduced sum to which he is entitled. If his report shows he is no longer entitled to any allowance because his income from employment is above $175 or $200, the veteran will have a chance to decide whether he wants to have the Veterans Administration discontinue supervision of his training so he can save the rest of his eligibility for other school or training courses later.

The Veterans Administration set November 5 as the deadline for receiving the reports from veterans who were in training at the time the law was passed. Not included in the group required to report earnings by November 5 were veterans who were in training but not receiving a subsistence allowance and those who entered or reentered school or training this fall. The latter filled out a different form when they entered. Disabled veterans enrolled under the Vocational Rehabilitation Act also are not affected.

INSURANCE AGAINST TOTAL DISABILITY

Veterans who have National Service Life Insurance now may be insured against total disability. Total disability income benefits authorized by recent legislation may be added to any plan of National Service Life Insurance on application, proof of good health and payment of an extra premium. In its announcement the Veterans Administration said that premium rates for the disability coverage range from 6 cents to 94 cents a month per thousand dollars of insurance, depending on the insured's age and type of policy. The disability benefits are at the rate of $5 a month for each thousand dollars of insurance and are payable after the veteran has been totally disabled continuously for six months or more. The monthly benefits will continue to be paid as long as the insured remains totally disabled. However, the disability must commence before the veteran's sixtieth birthday. The face value of the veteran's policy will not be reduced by any disability payments that he might receive.

Veterans with service connected disabilities less than total in degree are not prevented from taking advantage of the new provision, provided they apply for it before Jan. 1, 1950. In these cases such disabilities are waived if they are the only bar to meeting the health requirements. Veterans who wish to obtain full information about the new disability income feature should apply to their nearest VA office.

TEN WOMEN DOCTORS APPOINTED CONSULTANTS

Ten women doctors have been appointed as consultants on medical care for women veterans in Veterans Administration hospitals and homes, Dr. Margaret D. Craighill, former dean of the Women's Medical College of Pennsylvania, and VA's chief consultant on medical care for women veterans, has announced. This group, all veterans of World War II, will work with VA branch office and central office medical staffs in advisory capacities. The women consultants are Dr. Marian C. Loizeaux, Boston; Dr. Margaret Janeway, New York; Dr. Jane Liebfried, Philadelphia; Dr. Gertrude R. Holmes, Greenville, S. C.; Dr. Grace Haskin, Cleveland; Dr. Angie Connor, Fort Thomas, Ky.; Dr. Elizabeth D. Fletcher, Little Rock, Ark.; Dr. Eleanor B. Gutman, Coquille, Ore.; Dr. Hulda E. Thelander, San Francisco, and Dr. Ruth Bergess, Roosevelt, Utah.

CHINESE OFFICERS STUDY AMERICAN METHODS

Six Chinese army medical officers recently visited Dr. Paul R. Hawley, chief of the Veterans Administration medical service, to make a detailed study of procedures for handling problems of American war veterans. The Chinese administrative team is composed of Major Gen. Hsi-lin Hsu, surgeon general, Chinese army ground forces; Col. Chan Chao, army service forces; Col. Ling-sun Woo, division of medical service; Col. Tah-mou Peng, division of technical service; Col. Ping Shiao, division of rehabilitation, and Major Wen-tah Yang, hospital administration branch. These officers are spending six months in the United States studying the organization and functions of various military and civilian medical organizations for the purpose of revising the medical service of the Chinese Army.

PERSONAL

Dr. William S. McCann, head, Department of Medicine, University of Rochester School of Medicine and Dentistry, has been appointed to the Naval Research Advisory Committee, which will consist of not more than fifteen persons selected from civilian life to serve for one year. Dr. McCann served in the Army Medical Corps in World War I in Panama, England, France and Germany and in the Navy Medical Corps in World War II as chief of clinical activities on the U. S. S. *Refuge* during the North African campaign and during the invasions of Normandy, southern France and Italy.

VETERANS' HOSPITALS

The Veterans Administration was, as of Nov. 25, 1946, operating twenty-four former army and navy hospitals to meet the growing need for hospital space. Sites have been selected for sixty-three of the eighty-nine new hospitals that the Veterans Administration is authorized to build in the world's largest hospital construction program. The Veterans Administration cleared over 84,000 requests for physical examinations during September 1946 for pensions or compensations, the highest total to date.

TUBERCULOSIS HOSPITAL AT MADISON

The War Department has announced that army engineers have awarded the architect-engineer contract for the Veterans Administration Hospital at Madison, Wis. This is to be a 500 bed tuberculosis hospital. The engineers will advertise for construction bids after the preliminary plans have been converted into permanent plans. Work will be carried on under the supervision of the Upper Mississippi Valley Engineer Division and the Rock Island Engineer District.

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PHYSICIANS SEPARATED FROM SERVICE

ARMY MEDICAL CORPS OFFICERS RECOMMENDED FOR/OR RELIEVED FROM ACTIVE DUTY

Alabama

Anderson, William D.....Tuscaloosa
Boudreau, Floyd T.....Mobile
King, Hiram G.....Bessemer
McBurney, Robert P.....Tuscaloosa
Porter, Charles E.....Birmingham
Shell, James R.....Abbeville
Sullivan, Claude C. Jr.....Northport
Upchurch, Samuel E.....Clanton

California

Abbott, Arnold W.....Redlands
Barker, Robert C.....Modesto
Bartlett, Isaac E.....Inglewood
Boyes, Joseph H.....La Canada
Chase, Robert N.....Garden Grove
Dooley, Robert F.....Oakland
Gomes, Howard J.....Los Angeles
Gordon, Martin N.....Los Angeles
Hale, Fredric A.....Sacramento
Ho, Wayne Y.....Los Angeles
Hokholt, Carl A.....Stockton
Isoard, Max C.....Sacto
Klingel, Robert W.....San Francisco
Klor, Samuel J.....N. Hollywood
Kuffel, Mark J.....Los Angeles
Lee, George Q.....Oakland
Lowenstein, Bernard.....San Francisco
McEwen, William I.....Taft
McFarland, George E.....Los Angeles
Miller, Deibert J.....Pasadena
Naquet-Hamilton, Henry J.....Berkeley
Nittler, Alan H.....Santa Cruz
Persike, Edward C. Jr.....San Francisco
Putnam, Frank I.....Livermore
Richardson, George E.....Santa Monica
Rose, Clifton P. Jr.....Oakland
Rulison, Elbert T. Jr.....Napa County
Shearer, Edward J.....Colton
Torgerson, Thomas M.....Santa Rosa
Vollert, Edward F.....San Francisco
Walsh, John W.....Eureka

Colorado

Baker, William G.....Denver
Breitzer, Bernard.....Denver
Griffith, Eugene R.....Crowley
Harrington, Robert B.....Grand Junction
Leder, Max M.....Denver
McCunniff, William B.....Antonito
Motter, George N.....Trinidad
Shontz, William C.....Pueblo
Tarjan, George.....Denver

Connecticut

Bisaccia, Leonard J.....New Hartford
Craige, Branch Jr.....New Haven
Czyz, Stanley I.....Thomaston
De Wolfe, Victor G.....Stamford
Klebanhoff, Harry E.....New Haven
Shea, Cornelius J.....Bridgeport
Wolfson, Dexter.....Bethel

Florida

Baker, Juel M.....Miami
Barranco, Anthony J.....Lake Wales
Kartniol, Jerome.....St. Petersburg
Keller, Julian J.....St. Petersburg
Tanarkin, Samuel.....MacDill Field
Thomas, William C. Jr.....Gainesville

Georgia

Anderson, Robert T.....Hillsboro
Arrendale, Joel J.....Tiger
Avera, Bertram P. Jr.....Wrens
Butler, Clarence C.....Columbus
Erwin, Goodlow Y.....Athens
Hardman, Billy S.....Gainesville
Jackson, Robert T.....Macon
Klapper, Claude.....Atlanta
MacQuigg, David E.....Columbus
Wootten, Louis O.....Cordele

Illinois

Bedessem, Philip M. Jr.....Chicago
Blix, Fred M. Jr.....Chicago
Bornstein, Frederick P.....Chicago
Chung, Joseph T.....Chicago
Davis, Jack E.....Chicago
Fahnestock, Edward A.....Bridgeport
Falk, Nathan.....Chicago
Field, Robert E. H.....Blue Island
Fitch, Franklin R.....Villa Park
Foucek, B. Charles.....Berwyn
Grant, John F.....Glencoe
Hall, Thomas D.....Chicago
Huss, Norman C.....Chicago
Kass, Harold M.....Chicago
King, Walter W.....Peoria
Knudtson, Herbert M.....Chicago
Koff, Harold R.....Chicago
Kosse, James.....Chicago
McDonald, James A.....Wheaton
Martens, Edward J.....Chicago
O'Berto, Albert L.....Chicago
Oester, Yvo T.....Chicago
Pagano, Clarence J.....River Forest
Reischer, Adam.....Chicago
Rosner, David C.....Chicago
Schaffran, Morton.....Chicago
Shapiro, Joseph.....Chicago
Snead, Claude R.....Chicago
Soltes, Frank J.....Chicago
Souders, John C. Jr.....Rock Island
Stanton, George T.....Chicago
Stoddard, Leland D.....Mount Carmel
Sykes, Robert H.....Geneva
Walker, Allen E.....Chicago

Indiana

Aronson, Sidney S.....Indianapolis
Bunge, Clarence E.....Logansport
Hambley, William C.....Mishawaka
Kisner, Paul.....Terre Haute
McDonald, Richard.....Muncie
Talbott, Dan E.....Indianapolis

Kentucky

Borsch, Warren W. Jr.....Louisville
Estes, Woodrow B.....Williamsburg
Evans, Ira C.....Lexington
George, Eli J.....Louisville
Mauch, Stewart W.....Louisville
Rodgers, George M. Jr.....West Point
Talley, William R.....Louisville
Waldrop, Claude C.....Owenton

Louisiana

Baranco, Paul F.....Jackson
Bayon, Philip J.....New Orleans
Bostick, John N.....Gilbert
Carter, Sandy B.....New Orleans
Katz, Jerome B.....New Orleans
Le Blanc, Edward J. Jr.....Abbeville
McElwee, John R.....Mangham

Massachusetts

Angley, John C.....Bryantville
Bloomenthal, Herbert M.....Boston
Chase, Philip B.....Springfield
Codin, Kenneth (Name changed from "Cohen," Kenneth 13 Sept. 1943) Lynn
Cotsomas, Nicholas J. Jr.....Cambridge
David, Lloyd G.....Lowell
Elliston, William A.....Weston
Giddings, Lane.....Gt. Barrington
Hahn, Edward O.....W. Somerville
Hirsch, Frank A.....Andover
Kanter, Stanley S.....Boston
Kaplan, Melvin S.....Brookline
Kennan, Fred J.....Boston
Kilgore, Philip E.....Lynn
McGovern, Richard A.....Lawrence
Moore, Merrill.....Squantum
Morse, Edward K.....Waban
Peterson, Edwin W.....Boston

Massachusetts—Continued

Robinson, Benjamin R. Jr.....Worcester
Rosenberg, Isadore N.....Boston
Rosenberg, Joseph.....Fitchburg
Rowson, Walter Jr.....E. Braintree
Stitt, Albert A.....Brighton
Tabor, Edward O. Jr.....Lowell
Troubalos, Stephen.....Brighton
Wagner, Samuel L.....Boston
Woodruff, Richard S.....Pittsfield

Michigan

Armstrong, Richard C.....Ann Arbor
Asselin, Dean R.....Detroit
Backe, John C.....Corunna
Davidson, Harry O.....Detroit
McDonnell, Edward E.....Scottville
McGaughey, Clark G.....Ann Arbor
McGough, Joseph M.....Detroit
Maynard, Frederick M.....Detroit
Murphy, Timothy R.....Crystal Falls
Runde, Harold E.....Detroit
Rupp, Robert H.....Detroit
Rush, Alva D.....Battle Creek
Spagnuolo, Alfred J.....Mount Pleasant
Waring, Thomas P.....Ann Arbor
Wilson, Andrew G.....Detroit
Winegar, Alvon C.....Lapeer

Minnesota

Albers, George D.....Rochester
Armstrong, Ralph S.....Mahnomen
Arnesen, John F.....Newport
Avrick, Alan M.....St. Paul
Batdorf, B. Niles.....Maple Plain
Bossingham, Earl N.....Walker
Bushard, Marcus C.....New Ulm
Engstrom, William W.....Rochester
Enquist, Irving F.....Duluth
Falsetti, Frank P.....Rochester
Hunner, Earl E.....Duluth
Korum, Lyle W.....Minneapolis
Lagaard, Sheldon M.....Minneapolis
Litman, Neil N.....St. Paul
Nelson, Carl G.....Minneapolis
Nelson, Wallace I.....Minneapolis
Perkins, Roy F.....Rochester
Perry, John W.....St. Paul
Petersen, Glenn I.....Minneapolis
Rygh, Harold N.....Ashby
Tosseland, Noel E.....Milaca
Trow, William H.....Minneapolis

Mississippi

Applewhite, Austin H.....Columbia
Flautt, James R. Jr.....Swan Lake
Follo, Marshall I.....Ann Arbor
Izard, Samuel E. Jr.....Newhebron
McDill, John E.....Jackson
Rude, Joe C.....Jackson
Weems, William E.....Shubuta
Wigginton, Roy C.....Corinth
Yates, Claud F.....Canton

Missouri

Anthony, Dallas D.....Springfield
Arnoldi, Louis B.....Cape Girardeau
Ashley, Hugh V. Jr.....Cape Girardeau
Beatty, Arch J.....Warrensburg
Davis, Martin W.....Webster Groves
Eubank, Dillard M.....Raytown
Firminger, Harlan I.....St. Louis
Gunn, Richard W.....Kansas City
Kennedy, Walter J. Jr.....Sedalia
Krupkin, Nathan R.....St. Louis
Miller, Elmer B.....St. Louis
Miller, Richard C.....Kansas City
Motley, Hurley L.....Columbia
Peugnet, Hubert B.....St. Louis
Rusk, Howard A.....Brentwood
Stephens, Louis F.....St. Louis
Viviano, Joseph G.....St. Louis
Witt, Clyde M.....St. Joseph

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PHYSICIANS SEPARATED FROM SERVICE

New Jersey

Allen, Robert P.....Red Bank
Anderson, Robert C.....Newark
Apter, Abraham H.....Paterson
Aria, Charles J.....Jersey City
Arndt, Frank R.....Cliffside Park
Baime, Jules E.....E. Orange
Baldwin, John F.....W. Englewood
Barnett, Arthur M.....Ridgewood
Barroway, James N.....Camden
Beddall, John T.....Collingswood
Berk, Lester I.....Red Bank
Blasi, Benjamin R.....Newark
Bowen, Robert N.....Woodlynne
Brady, Edwin H.....Arlington
Braun, Edgar M.....Newark
Braveman, Bernard L.....Princton
Copeland, Glenn J.....Arcade
Davidson, Jack D.....Glen Ridge
Esterman, Louis M.....E. Paterson
Eynon, James R.....Collingswood
Fahrenbruch, Frederick D...Mount Holly
Fairlie, Chester W. Jr.....Essex Falls
Friedman, Sidney.....Jersey City
Harley, Robison D.....Pleasantville
Heus, E. George.....Fort Lee
Ledden, Lewis J.....Trenton
McCormack, Raymond A. Jr....Trenton
Miniszek, James H.....Avon
Movelle, John B.....Asbury Park
Nimaroff, Harold.....Newark
Ransom, Leland B.....Westfield
Rusin, Michael J.....Garfield
Saxe, Theodore L.....Passaic
Sussman, Irvin.....Woodbury
Taffet, Seymour.....Belleville
Triolo, John V.....Summit
Wert, Earl B.....Westmont

New York

Alpert, Herman S.....Thielle
Amoruso, John.....New York
Amster, Milton W.....Brooklyn
Arnold, Samuel A.....Bay Shore
Avitabile, Adrian R.....Brooklyn
Bacchiani, Torquato L.....Nesconset
Bacile, Victor A.....Poughkeepsie
Bailey, Harmon J.....Rye
Bantleon, George F.....Rochester
Barbour, Paul H. Jr.....Brooklyn
Bickerman, Hylan A.....Forest Hills
Bone, Kenneth W.....Kenmore
Bowen, Raymond J.....Binghampton
Bryan, Fred A.....Rochester
Carra, Angelo D.....New York
Dale, John H. Jr.....New York
Daniels, Melvin R.....Yonkers
Drenick, Ernst J.....New York
Drucker, John J.....Forest Hills
Eckel, John E.....Albany
Engel, Edward F.....Seneca Falls
Evans, Alfred S.....Buffalo
Fabricante, Salvatore P.....Brooklyn
Gesualdi, James.....Bronx
Gillen, Theodore E.....Cohoes
Gloster, Cecil C.....Brooklyn
Griffith, Newell J.....Tuckahoe
Hill, Donald B.....New York
Horowitz, Sender.....Brooklyn
Joslin, Doyle.....New York
Kanzer, Mark G.....New York
Kasper, Louis.....Jamaica
Kassop, Harry.....Forest Hills
Kennedy, Putnam C.....Catskill
Kersten, Gerhard.....Forest Hills
Kime, James S.....Buffalo
King, Byron B.....Rochester
Komora, Edward J.....Jackson Heights
Kramer, Leonard.....Brooklyn
Krawczyk, Joseph F.....Buffalo
Kristal, Jackson J.....New York
Kwalwasser, Simon.....Orangeburg
Lambert, John P.....Katonah
Levine, Hyman J.....Brooklyn
McCoy, Stephen M.....Brooklyn

New York—Continued

Mayer, Robert A.....Richmond Hill
Mayo, Maxim A.....Cohoes
Mehlman, Alexander.....Wassaic
Moore, Frederick T.....Utica
Nadell, Raymond.....Brooklyn
Parnell, Vincent A.....Middle Village
Persons, Ray E. Jr.....Cairo
Petersen, Walter R.....Buffalo
Polinger, Elliot C.....New York
Ross, George L.....New York
Rowe, Linwood M.....Plattsburg
Sass, Raymond W.....New York
Schantz, Benjamin A.....Middletown
Schettini, Vincent R.....Newburgh
Schneer, Henry I.....Brooklyn
Shelton, Henry Z.....Orangeburg
Silberman, Norman.....Brooklyn
Soltz, Samuel E.....New York
Starr, Felix.....Brooklyn
Stiles, David.....Scarsdale
Stock, Robert.....Long Island City
Sweet, Byron L. Jr.....Tarrytown
Tabacco, Salvatore.....Albany
Thanos, Daniel.....Syracuse
Verdone, George F.....Glendale
Weinstein, Joseph.....Brooklyn

Ohio

Anderson, Robert A.....Wooster
Artman, Edwin H.....Chillicothe
Ayres, Roland W.....Alger
Ayres, William B.....Dayton
Bahrenburg, James H.....Canton
Baker, Philip H.....Columbus
Basnett, Carl M.....Columbus
Davis, John W.....Cleveland
Drury, Walter A.....Willard
Ersay, Emil F.....Cleveland
Fox, Wesley B.....Cincinnati
Garber, Pauline E.....Sugarcreek
Hale, Nathan S.....Wilmington
Johnston, G. W. Jr.....New Philadelphia
Keeling, Virgil C.....Mt. Healthy
Kessler, Dale L.....Hamilton
Kyman, Seymour.....Cleveland Heights
Lapp, Warren A.....Cincinnati
Makley, Torrence A. Jr.....Dayton
Moffatt, Robert E.....Shelby
Oppenheim, Heinz.....Cleveland
Owens, Andrew J.....Youngstown
Riemer, Robert W.....Norwood
Ritchey, Arthur F.....Cincinnati
Schoenberger, James A...Cleveland Hgts.
Seikel, George R.....Akron
Stahl, Richard H.....Akron
Wagner, Charles A.....Youngstown
Wertheimer, Daniel S....Cleveland Hgts.
Wilke, Richard M.....Cleveland

Pennsylvania

Aronson, Morton L.....Pittsburgh
Auslander, Milton M.....Lancaster
Ballard, George T.....Pittsburgh
Barnes, Benjamin C.....Ardmore
Battaglia, Albert J.....Philadelphia
Bauer, William A.....Turtle Creek
Bittenbender, Glace E.....Nescopeck
Brown, Arthur E. Jr.....Harrisburg
Cooper, LeRoy G.....Glen Lyon
Crispell, Kenneth R.....Sayre
Dudnick, Henry J.....Philadelphia
Esman, Morris.....Pittsburgh
Ferri, Henry G.....Carnegie
Frankel, Kalman.....Philadelphia
Gan, Walter S.....Philadelphia
Hale, Thomas K.....Frackville
Heckman, James A.....Wilkinsburg
Ivker, Morris.....Philadelphia
Jacobs, Francis.....West Chester
Kearney, Martin J.....Philadelphia
Keiserman, Joseph.....Philadelphia
Kephart, Stewart B.....Philadelphia
Killius, William J.....Johnstown
King, Cedric S.....Bryn Athyn

Pennsylvania—Continued

Klein, Joseph M.....Wilkes-Barre
Krause, Seymoure.....Braddock
Krick, John H.....Export
Levinson, David C.....Harrisburg
Light, John H.....State College
McGovern, William J.....Carnegie
Marks, Meyer A.....Philadelphia
Morrison, Roger W.....Pittsburgh
Null, Robert H.....Philadelphia
Petroff, George N.....Uniontown
Pfromm, John.....Allentown
Ross, Joseph G.....Spring City
Ruth, John F.....Wyomissing
Schaffner, Bertram H.....Erie
Silverstein, Donald J.....Scranton
Valigorsky, Paul J.....Six Mile Run

Tennessee

Armstrong, Charles M.....Knoxville
Baird, Jesse P.....Dyersburg
Kennedy, James A.....Nashville
Kimsey, Warren H.....Memphis
Knapp, John A.....Mountain Home
Murrah, William F. Jr.....Memphis
Rozzell, James D.....Gibson
Ryan, Joseph M.....Knoxville
Tandeta, Morris.....Memphis

Texas

Anspach, Harold M.....Waco
Austin, Carl M.....Dallas
Barnes, Maurice C.....Waco
Beall, James F.....Nacogdoches
Christian, John J.....Temple
Ellis, John M. Jr.....Mt. Pleasant
Fife, Ray.....Dallas
Finney, James W.....Coleman
Gordon, Clarence E.....Eddy
Hatchett, Capres S. Jr.....Amarillo
Irvine, George N. Jr.....McCamey
Jackson, Claude L.....Ranger
McDonald, Donald H.....Abilene
Spark, Milton.....Waco
Tanaka, Paul A.....El Paso

Utah

Evans, Carvel S.....Salt Lake City
Finch, Stuart M.....Salt Lake City
Loomis, Walter F.....Salt Lake City
MacFarlane, Alan P.....North Logan

Vermont

Pine, Louis F.....Burlington
Ross, Ivan B.....St. Albans

Washington

Beatty, John H.....Everett
LanGevin, William A.....Yakima
Lindel, Marion C.....Raymond
Lucas, John E.....Seattle
Parmelee, Ernest B.....Seattle
Philips, Clifford W.....Seattle

West Virginia

Cianos, James N.....Clarksburg
Escue, Henry M.....St. Albans
Haislip, Charles A.....Valley Grove
Hall, Jack H.....Morgantown
Hutchinson, Bernard M.....Sutton
Kinney, Earl R.....Ida May
Lynch, Richard V. Jr.....Clarksburg
Marlowe, William H.....Sutton
Sanders, Zack W.....Bluefield
Wells, Warner L.....Clarksburg

Wisconsin

Conway, John E.....Spring Valley
Coon, William L.....Milwaukee
Gorenstein, Leonard.....Milwaukee
Heilman, Richard B.....Richland Center
Kimber, Karl E.....Waukesha
Kleinhans, Henry M.....Wauwatosa
Nordby, Eugene J.....Baldwin
Wenger, Harold A. E.....Madison

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Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST: SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION AND PUBLIC HEALTH.)

CALIFORNIA

Laboratory of Experimental Oncology.—The establishment of a new cancer research unit by the U. S. Public Health Service and University of California Medical School, San Francisco, was announced December 4, according to the New York *Times*. To be known as the Laboratory of Experimental Oncology, the project will be set up at the Laguna Honda Home here and will be jointly conducted by the Medical School and the Public Health Services of the National Cancer Institute. Dr. Francis S. Smyth, dean of the medical school, said the research work would be coordinated not only with the cancer program of the University of California Medical School but also with similar work at the Stanford University School of Medicine. Dr. Michael B. Shimkin, Bethesda, Md., surgeon attached to the National Cancer Institute, who was graduated from the University of California Medical School in 1937, and Comdr. Howard R. Bierman of the Naval Medical Corps will represent the Public Health Service on the project. Commander Bierman is with the Naval Medical Research Institute at the National Naval Medical Center at Bethesda, Md. Dean Smyth said the research would be carried on through the cooperation of Dr. J. C. Geiger, director of public health for this city, and Mr. Thomas A. Brooks, chief administrative officer of San Francisco.

CONNECTICUT

Conference on Medical Social Work.—At the thirty-sixth annual conference of social work in Bridgeport, November 14-15, four of the twenty-six panel discussions were devoted to medical subjects, as follows: Dr. Frederick C. Redlich, assistant professor of psychiatry, Yale University School of Medicine, New Haven, "Social and Emotional Aspects of Illness"; Dr. Edward H. Truex Jr., Hartford, Conn., "Rehabilitation of the Aurally Handicapped"; Dr. A. Nowell Creadick, New Haven, chairman of the Commission to Study the Needs of the Chronically Ill and Aged, "Care of the Aged"; Dr. Arthur Bliss Dayton, New Haven, "The Chronically Ill."

DISTRICT OF COLUMBIA

New Appointments at Georgetown.—Included among the changes in the faculty of Georgetown University of Medicine, Washington, are:

Dr. Charles F. Geschickter, Baltimore, professor and director of the department of pathology.
Walter C. Hess, Ph.D., Washington, professor and director of the department of physiologic chemistry.
Dr. Lloyd G. Lewis, Baltimore, associate professor of urology.
Dr. Charles P. Howze, Washington, professor of clinical urology.

KENTUCKY

Personal.—Dr. Edward M. Thompson, Russellville, has been appointed acting director of the Lexington-Fayette County Health Department.——Dr. Oscar V. Brown, Island, has been appointed health officer of McLean County.——Dr. Jesshill K. Love, Herrods Creek, has been appointed medical director of the eleven cancer clinics operating in the state, according to newspaper reports of a statement of Dr. Francis G. Aud, Louisville, chairman of the state executive committee, Kentucky division, American Cancer Society.

LOUISIANA

Personal.—Dr. Orville J. Richardson, Shreveport, has been appointed superintendent of the Pineville Charity Hospital, succeeding Dr. Marion H. Foster, resigned, effective September 1.

Research Fund in Gynecology.—The B. Bernard Weinstein Gynecological Research Fund has been created by patients and friends of Dr. Weinstein, assistant professor of gynecology, Tulane University of Louisiana School of Medicine, New Orleans. The interest derived from this fund is to be used for research in gynecology and is available to any member of the staff of Tulane University doing research in the field.

Alton Ochsner Wins *Times-Picayune* Loving Cup.—Dr. E. W. Alton Ochsner, professor of surgery and director of the department, Tulane University, Louisiana School of Medicine, New Orleans, has been chosen as the 1945 recipient of the *Times-Picayune* Loving Cup. Dr. Ochsner was awarded the cup for his contribution of local and national scope, both of a medical and civic nature. He and his associates are responsible for the establishment in 1943 of the Alton Ochsner Medical Foundation for education, research and charity. The *Times-Picayune* Loving Cup was established in 1940. Dr. Ochsner is the fourth physician to receive the award, the others being Dr. Rudolph Matas, New Orleans, in 1941 (THE JOURNAL, Nov. 22, 1941, page 1797), and the late Drs. Arthur W. De Roalds in 1905 and Sara T. Mayo in 1910.

MAINE

Clinical Program in Bangor.—The Maine Medical Association conducted a clinical session in Bangor, December 1-2, under the auspices of the Penobscot Medical Association. Clinics were held at the Eastern Maine General Hospital, Bangor, Bangor Sanatorium and Bangor State Hospital. The speakers at a dinner session were Dr. Richard B. Cattell, Lahey Clinic, Boston, "Surgery of the Intestine," and Dr. Chester S. Keefer, Evans Memorial Hospital, Boston, "Use of Antibiotics in Medicine."

MASSACHUSETTS

Changes in Faculty.—Included among recent appointments to Harvard Medical School, Boston, are Dr. Maxwell Bovarnick, Wilton, Conn., assistant professor of bacteriology and immunology; Dr. Seymour J. Gray, Chicago, assistant professor of medicine, and Dr. DeWitt Stetten Jr., New York, assistant professor of medicine.

MINNESOTA

The Rigler Lectureship.—Dr. Nils Westermark of the University of Stockholm, Sweden, gave the Leo G. Rigler Lectureship at the University of Minnesota Medical School, Minneapolis, November 26. His subject was "New Experimental Studies on Pulmonary Circulation."

Personal.—Members of the Slayton Civic and Commerce Association held a dinner in honor of Dr. Leon A. Williams, Slayton, on November 15 in recognition of his completion of fifty years in the practice of medicine in Slayton and Murray counties. Dr. Williams was presented with a pen and pencil set.——Dr. Thomas H. Shastid observed his eightieth birthday in Duluth recently.

MISSISSIPPI

Advisory Council for Hospital Care.—A state advisory council has been created by the Mississippi Commission on Hospital Care. The council membership is made up of thirty-five citizens representing their various professions and interests throughout the state. It will consult with and advise the commission in determining the hospital needs of the state.

NEW YORK

Director of State Tuberculosis Hospitals.—Dr. Ralph Horton, superintendent of the Homer Folks State Tuberculosis Hospital, Oneonta, since 1934, has been appointed general director of tuberculosis hospitals, division of tuberculosis, New York State Department of Health.

New York City

Proposed City Health Council.—The organization of a "Health Council of Greater New York" is now being developed to serve as a joint planning board through which the existing health organizations can work out their programs in relation to, and in cooperation with, each other, and with citizen groups. The officers are Mr. E. Roland Harriman, president, and Mrs. Shepard Krech, secretary.

Faculty Changes at Long Island.—Included among recent changes in the faculty at Long Island University College of Medicine are:

Dr. Charles A. Gordan, Brooklyn, appointed director of the department of obstetrics and gynecology, succeeding Dr. Alfred C. Beck.
Dr. Morris Glass, Brooklyn, Dr. Frank P. Light, Brooklyn, Dr. William Meagher, Brooklyn, Dr. J. Thornton Wallace, Jackson Heights, and Dr. George Hamilton, New York, appointed clinical professors in the department of obstetrics and gynecology.
Dr. Robert L. Moorhead retired as executive head of the department of otolaryngology with the rank of emeritus professor of otolaryngology.
Dr. Stuart A. Winning, Brooklyn, appointed assistant clinical professor of surgery.
Dr. William Dock, Brooklyn, appointed director of medicine on the College Division at Kings County Hospital.

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Dr. George H. Lordi, Brooklyn, Dr. John B. D'Albora, Brooklyn, and Dr. Morris M. Banowitch, Brooklyn, appointed clinical professors in the department of medicine.
Dr. S. Charles Franco, Brooklyn, appointed assistant clinical professor in the department of medicine.
Drs. John Pepe, Brooklyn, and Leo A. Harrington, Brooklyn, appointed assistant clinical professors in the department of radiology.
Dr. Thurman B. Givan, Brooklyn, appointed professor of clinical pediatrics.
Dr. Emil Smith, Brooklyn, appointed assistant clinical professor of pediatrics.

OHIO

New County Publication.—The Journal of the Clark County Medical Society recently made its appearance, with Dr. Howard H. Ingling, 308 East High Street, Springfield, as chairman of the publication committee. Other members, all of Springfield, are Dr. Ray M. Turner, Dr. William P. Ultes and Dr. George M. Lane. Mr. Frank C. Bateman, 304 East Columbia Avenue, Springfield, is the business manager.

The Lower Lecture.—The William E. Lower Lecture was presented November 15 by Dr. Cornelius P. Rhoads, New York, on "Recent Advances in the Treatment of Cancer." The lecture was the ninth in a series sponsored by the Academy of Medicine of Cleveland at the Cuyahoga County Medical Society. The series was made possible by a grant of money given by Dr. William E. Lower to endow a lectureship in medicine.

Memorial to Dr. Moore.—A portrait of the late Dr. Edgar H. Moore, presented to the board of trustees of the Columbus Public Library, will be displayed in that building as a permanent memorial to a brilliant young physician whose death brought about the library's acquisition of a trust fund for medical books. Dr. Moore, who died in 1904 at the age of 28, was stricken after five years of practice. His mother, who died May 20, 1935, left her estate to the city of Columbus to the library for the purchase of literature relating to incurable diseases as the Dr. Edgar Howard Moore Foundation. The estate has been invested by the city, and the income will always be available for the original purpose.

Personal.—Dr. Archelaus D. Harvey, Lebanon, has been appointed for a two year term as health commissioner of Warren County.——Dr. Forder F. DeMuth, Hicksville, has resigned as Defiance County health commissioner.——Emil Bozler, Ph.D., has been promoted to professor of physiology at the Ohio State University College of Medicine, Columbus. ——John A. Louis, Columbus, has been appointed executive secretary of the Ohio Tuberculosis and Health Association, succeeding Robert G. Paterson, Ph.D., who has retired after holding the position for thirty-five years. Dr. Paterson, who has been given the title of executive secretary emeritus and as director of research, will write a text in Community Health Organization for the School of Social Administration, Ohio State University, a history of the tuberculosis movement in Ohio and a history of the public health movement in Ohio.——Dr. Warren L. Hogue Jr. has been appointed medical department head for Firestone Tire and Rubber Company, Akron, to succeed Dr. Dan Moore McDonald, who retired on September 1 after forty years of medical service with the company. ——Enrique E. Ecker, Ph.D., professor of immunology, Western Reserve University School of Medicine, Cleveland, has been made a member of the Royal Academy of Medicine of Spain. Dr. Ecker has been lecturing in various cities abroad.

PENNSYLVANIA

New Director of Tuberculosis Control.—Dr. Morrison C. Stayer, Carlisle, who retired from the Army with the rank of major general, has been appointed director of the Bureau of Tuberculosis Control in the State Department of Health. Dr. Stayer will succeed Dr. Dale C. Stahle, Harrisburg, who has been acting director of the bureau since February and who has resigned to enter private practice.

TENNESSEE

Exposé of Naturopathic Diploma Mills.—Creation of a permanent investigating committee of all healing arts in Tennessee will be advocated by the American Naturopathic Association of Tennessee when the legislature convenes next month, the Nashville *Banner* reported December 9. The legislature will be urged to "put teeth" in the basic science law "in order to rid the profession of undesirables." It was stated that the action is prompted by the discovery that many persons licensed to practice naturopathy in Tennessee were not qualified, and some had obtained licenses without taking an examination, but actually it followed an entire exposé of the illegal practices of the board of naturopathic examiners by the state, stemming from the activities of the Memphis *Commercial-Appeal*. Several naturopaths have been arrested and are under heavy bonds pending trial. Another naturopathic group is the Tennessee Association of Naturopathic Physicians, Inc., which was formed in October 1945 "to combat unscrupulous and illegal practices thought to be destroying the standing of naturopathic physicians practicing in accordance with the naturopathic bill. . . ." The entire investigation is being carried on by the state, and some indictments have already been made. One attorney for the state is reported to have said that "an allegedly phony naturopathic and homeopathic racket of international scope" had been smashed in Tennessee with the cooperation of the *Commercial-Appeal*. Investigators said that a medical doctor, whose name was not divulged, assisted in the investigation after one naturopath made an offer to obtain a "genuine homeopathic license for practice in the state of Arkansas." The doctor sent a check for $150 through one William Faulkner, it was stated, $50 of which was to pay for the license. The investigation by the state has disclosed the illegal practices of the state board of naturopathic examiners, specific members of which have been accused of operating scores of diploma mills throughout the state and elsewhere in the United States and Canada.

TEXAS

Spring Clinical Conference.—The sixteenth annual Spring Clinical Conference of the Dallas Southern Clinical Society will be held in Dallas, March 17-20. Participating in the conference will be:

Dr. Elmer Belt, Los Angeles, Urology.
Dr. William Boyd, London, Pathology.
Dr. Frank D. Dickson, Kansas City, Mo., Orthopedic Surgery.
Dr. Francis Fralick, Ann Arbor, Ophthalmology.
Dr. Leo H. Garland, San Francisco, Radiology.
Dr. George H. Humphreys II, New York, Surgery.
Dr. John R. Lindsay, Chicago, Otolaryngology.
Dr. Perrin H. Long, Baltimore, Preventive Medicine.
Dr. Henry G. Poncher, Chicago, Pediatrics.
Dr. Isidor S. Ravdin, Philadelphia, Surgery.
Dr. Ralph A. Reis, Chicago, Obstetrics and Gynecology.
Dr. Newton D. Smith, Rochester, Minn., Proctology.
Dr. Willard O. Thompson, Chicago, Medicine.
Dr. John C. Whitehorn, Baltimore, Neuropsychiatry.
Dr. Julius L. Wilson, New Orleans, Medicine.

VIRGINIA

Changes in Health Personnel.—Dr. James Dudley, health commissioner of Newport News, has resigned to accept a similar position with the city of Roanoke, effective September 1.——Dr. Henry C. Bradford, Falls Church, has been appointed health officer of Fairfax County, with headquarters in Fairfax, effective November 1.——Dr. James A. Fields has been appointed health officer of Pittsylvania and Halifax counties, with headquarters in South Boston, effective November 15. ——Dr. B. Randolph Allen, director of the bureau of communicable diseases, Virginia State Department of Health, has resigned to join the Veterans Administration.——Dr. William A. Browne, assistant director, Richmond department of health, has resigned, effective December 1.

WASHINGTON

Personal.—Dr. Park W. Willis Sr. has been named president of the Pioneer Association of Washington State. Dr. Willis has practiced in Seattle since 1892.——Dr. James A. Durrant, who had practiced in Snohomish for more than forty-four years and who served three years as state representative, has retired.——Dr. Herbert E. Tomlinson, Washington, D. C., recently released from military service, has been appointed industrial consultant for the industrial and adult hygiene section of the Washington State Department of Health.——Dr. Burton A. Foote, Ellensburg, has been temporarily appointed health officer of Kittitas County, succeeding Dr. Conrad E. Rosdahl, Spokane, resigned.——Dr. Bayard T. Blake was recently presented with $1,300 from the community of Darrington, where he had been practicing for forty years, to enable him to attend the recent world series.——Dr. Charles E. Reddick, Paducah, Ky., has been named health officer of Pierce County, succeeding Dr. Harold Marks, Washington, D. C., who has joined the staff of Pierce County Medical Bureau.——Dr. Sherman S. Pinto has been appointed medical director of the Tacoma Smelter of the American Smelting and Refining Company. Dr. Pinto, before he entered military service, was in charge of the division of industrial hygiene of the Louisiana State Board of Health, New Orleans.

WEST VIRGINIA

Dr. Spray Retires.—Robb S. Spray, Ph.D., has retired as professor of bacteriology at West Virginia University School of Medicine, Morgantown, with the rank of professor emeritus. Dr. Spray held the position for twenty-five years.

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WISCONSIN

University News.—Dr. Clarence Knight Aldrich, formerly of Winnetka, Ill., recently of the U. S. Public Health Service, has been appointed assistant professor of neuropsychiatry in the department of student health at the University of Wisconsin Medical School, Madison.

GENERAL

Questionnaire on Private Practicing Psychiatrists.—The Maryland Association of Private Practicing Psychiatrists is sending out a questionnaire to obtain information on the need of a central body for discussing and solving problems incident to the office practitioner. The Maryland association was formed some two years ago and the feeling for a central organization stems from this group. Dr. Jean N. Cushing is secretary of the Maryland Association of Private Practicing Psychiatrists, 11 East Chase Street, Baltimore 2.

Nobel Prize Winners Honored.—Portraits of five American scientists who were awarded Nobel prizes in 1946 and selections from their scientific writings are being displayed in the Library of Congress from November 19 through December 31. The five scientists honored in the exhibit are:

Professor Percy W. Bridgman, Harvard University, awarded a Nobel prize in Physics for work on high pressure;

Dr. J. H. Northrop, Rockefeller Institute, awarded a Nobel prize in chemistry for work on the chemistry of enzymes and viruses;

Professor H. J. Muller, Indiana University, awarded a Nobel prize in medicine and physiology for work on the effect of roentgen rays on genes and chromosomes;

Dr. Wendell M. Stanley, Rockefeller Institute, awarded a Nobel prize in chemistry for work on the chemistry of viruses, and

Professor James B. Sumner, Cornell University, awarded a Nobel prize in chemistry for work on enzyme chemistry.

Meeting on Antibiotics.—Hans T. Clarke, D.Sc., chairman of the antibiotics study section of the National Institute of Health, a group of civilian consultants organized for the purpose of promoting research investigations in the field of antibiotics, announces that the Study Section's next meeting will be held in Washington, D. C., on Jan. 31 and Feb. 1, 1947, in conjunction with the commercial producers of the various antibiotics and with others interested in antibiotic research. Although it is not possible to defray travel expenses, all interested investigators in the field of antibiotics are invited to attend this two day national conference. Inquiries concerning details of this meeting and the presentation of scientific reports should be addressed to Gordon Seger, Ph.D., Executive Assistant, Antibiotics Study Section, National Institute of Health, Bethesda 14, Md.

New Grants of Nutrition Foundation.—On November 14 the Nutrition Foundation approved renewals of grants amounting to $29,050 and eight new grants totaling $28,800. The Nutrition Foundation, Mr. George A. Sloan, president, reported, has made thirty-three grants totaling $1,267,305 to fifty-three universities and medical centers in the United States and Canada. The work of the foundation has been supported by contributions totaling $2,318,000 made by food and related manufacturers. The new grants made by the Board of Trustees include:

Olaf Bergeim, Ph.D., University of Illinois College of Medicine, Chicago, $3,000 to study ten or more individual amino acids in human and animal blood, tissues, sweat and spinal fluid in health and disease.

Paul D. Boyer, University of Minnesota School of Medicine, Minneapolis, $2,600 to study the mechanism of the action of vitamin E and especially the relationship between deficiencies and impaired functions of the muscles. Preliminary findings have shown striking effects of chronic deficiencies causing heart failure in larger animals.

Ralph I. Dorfman, Ph.D., Cleveland, Joseph T. Wearn, Western Reserve University, $3,400 to study the nature of relationships between vitamins and hormones.

Carl M. Lyman, Ph.D., Oakland, Texas, A. & M. College of Texas, $2,000 annually for two years to study the steps by which amino acids are synthesized by living organisms.

Joseph H. Roe, Ph.D., George Washington University School of Medicine, Washington, D. C., $3,600 to study methods for making an analytic distinction between two or possibly more of the oxidation products of vitamin C.

Edward L. Tatum, Ph.D., Yale University School of Medicine, New Haven, Conn., $2,500 annually for two years to study new technics of inducing new strains of bacteria, molds and so on by means of chemical irritants.

Wilfred W. Westerfeld, Ph.D., Syracuse, University College of Medicine, $3,000 annually for two years to study the changes undergone by sugars in the animal body and the relation of such changes to the functional role of certain vitamins in the B complex.

James G. Wilson, Ph.D., New York University of Rochester, $1,200 to study and analyze the malformations produced in fetal and newborn rats by maintaining the mothers on a diet deficient in vitamin A.

Narcotic Violations.—The Bureau of Narcotics, U. S. Treasury Department, Washington, D. C., recently reported the following:

Dr. Charles F. Abney, Knoxville, Tenn., pleaded guilty in the U. S. District Court at Knoxville, May 29, to violation of the Harrison Narcotic Law and was sentenced June 5 to serve eighteen months in the penitentiary. The sentence was to be served consecutively on counts one and two; sentence was suspended on count three; he was placed on probation for five years and fined $100 on count four.

Dr. Wayne D. Daugherty, Grove City, Pa., pleaded guilty in the U. S. District Court of Pittsburgh to violation of the Harrison Narcotic Law. Sentence was suspended, and he was placed on probation for five years, ordered to pay costs and to voluntarily enter the U. S. Public Health Service Hospital, Lexington, Ky., for the treatment of narcotic addiction.

LATIN AMERICA

Health Activities in Latin America—*The Pan American Doctors' Club.*—The Pan American Doctors' Club was incorporated in August in Mexico as a nonprofit association and has taken over the club home at San Miguel Regla, 70 miles northeast of Mexico City. Membership in the club is by invitation. Its chief aims are to achieve a closer understanding between the physicians of the Americas and to facilitate in every way possible a solution of the health and general welfare problems of the peoples of the Western Hemisphere as well as to use the club home as a vacation spot for its members. It is planned to have members drawn mainly from the medical profession, but with the inclusion of 35 per cent of cultured people from other walks of life, such as educators, dentists, clergymen and engineers, to whom the purposes and opportunities for pleasant association at the club might appeal. As far as possible, membership will be kept evenly divided between Latin-American countries and those north of the Rio Grande. Plans are under way to create a model dairy farm. Two medical student graduates are now stationed at the club to begin the cleanup and sanitation of the neighborhood. The work is being carried out under the direction of Dr. Miguel Bustamante, subdirector, Institute for Tropical Diseases, Mexico, D. F. Request for reservations or information should be addressed to San Miguel Regla, box 6, Real del Monte, Hidalgo, Mexico, or to Dr. Clarence A. Mills, secretary-treasurer of the club, Cincinnati General Hospital, Cincinnati.

Campaign Against Tuberculosis.—Dr. Rubin M. Lewis, Philadelphia, is in Guayaquil, Ecuador, to direct a campaign against tuberculosis under the auspices of the Ecuadorian Anti-Tuberculosis League, sponsored by the Ecuadorian government. The Philadelphia *Record*, September 22, stated that Dr. Lewis would organize three tuberculosis hospitals, two in Guayaquil and one in Quito.

New Latin American Society.—The Sociedad Argentina de Patologia Infecciosa y Epidemiologia was recently organized, with headquarters in Buenos Aires, to advance the knowledge and measures for the prevention and control of infectious diseases and to intensify cultural and intellectual relations and scientific interchange with national and foreign societies pursuing similar aims. Officers elected include Dr. Julio Mendez, president; Dr. Carlos Fonso Gandolfo, vice president, and Dr. Julio Hansen, general secretary.

CORRECTION

Brutalities of Nazi Physicians.—The editorial in THE JOURNAL November 23, page 714, mentions as one of the three scientists indicted in Nuremberg a Dr. Sigmund Schilling. A correspondent writes that the daily press has reported Dr. Klaus Schilling as having been responsible for the brutalities performed by German physicians under the Nazi régime, and that, as far as he knows, a Dr. Sigmund Schilling was not known as a scientist in Germany in 1933.

Marriages

ALBERT C. ENGLAND JR. to Miss Priscilla Stern, both of Boston, in Marblehead, Mass., September 15.

WILLIAM DAVIS VAIL, Hyannis, Mass., to DR. ADELE OLNEY STEVENS of Short Hills, N. J., September 21.

HERBERT MATSNER GRUENBERG to Miss Elaine Kathryn Rosness, both of Los Angeles, October 12.

WILLIAM N. EDDY, Boonville, N. Y., to Miss Katherine Elmore in Blackstone, Va., September 7.

JOSEPH R. FOX, Philadelphia, to Miss Jane Jarrett of Quakertown, Pa., September 8.

ORRIN E. ANDERSON to Miss Margaret Harper, both of New York, October 12.

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Deaths

James Murray Flynn ✠ Rochester, N. Y.; University of Buffalo School of Medicine, 1914; member of the House of Delegates of the American Medical Association from 1938 to 1941 and from 1943 to 1946; consultant in radiology at the University of Rochester School of Medicine and Dentistry; specialist certified by the American Board of Radiology; fellow of the American College of Physicians; past president of the Medical Society of the State of New York and the Medical Society of the County of Monroe; member of the American Roentgen Ray Society, Radiological Society of North America, American College of Radiology and the American Radium Society; served in the U. S. Army with the American Expeditionary Forces during World War I; affiliated with Strong Memorial Hospital, Monroe County Infirmary, Park Avenue and St. Mary's hospitals; died December 14, aged 63, of coronary disease and pneumonia.

Victor Darwin Lespinasse ✠ Chicago; born in Aurora, Ill., Dec. 2, 1878; Northwestern University Medical School, Chicago, 1901; interned at Cook County Hospital; associate professor of urology at his alma mater; specialist certified by the American Board of Urology; member of the American Urological Association; fellow of the American College of Surgeons; past president of the Englewood Branch of the Chicago Medical Society; past president of the Chicago Urological Society; in 1910 the American Medical Association awarded him a Certificate of Honor for method of blood vessel anastomosis, in 1917 the Silver Medal for exhibit on obstructive sterility and in 1920 the Certificate of Merit for experiments on spermatogenesis and sterility; affiliated with the Wesley Memorial Hospital, where he died December 14, aged 68, of coronary thrombosis.

Joseph Krafka Jr., Augusta, Ga.; University of Georgia School of Medicine, Augusta, 1933; born in Ottumwa, Iowa, Aug. 14, 1890; professor and head of the department of zoology at the University of Georgia in Athens from 1919 to 1926 when he became professor and head of the department of microscopic anatomy at his alma mater; instrumental in the founding of the Georgia Academy of Science; member of the American Society of Zoologists, the Entomological Society of America, the American Association of Anatomists and the Sigmi Xi honorary science fraternity; contributor of a series of papers dealing with the medical history of Georgia, arteriosclerosis and human embryology; author of "Human Embryology" and a "Textbook of Histology"; died in the University Hospital November 5, aged 56, of nephritis.

Louis Samuels Deitchman, Youngstown, Ohio; University of Pennsylvania School of Medicine, Philadelphia, 1921; member of the American Medical Association and the American Academy of Ophthalmology and Oto-Laryngology; served as treasurer for the Mahoning County Medical Society; specialist certified by the American Board of Otolaryngology; interned at the Youngstown Hospital Association, where he was a member of the staff; affiliated with the Mahoning Tuberculosis Sanatorium; began active duty as a major in the medical corps, Army of the United States, in August 1942 and was separated from the service with the rank of lieutenant colonel in April 1946; died September 4, aged 52, of coronary occlusion.

Charles H. Boissevain ✠ Broadmoor, Colo.; Universiteit van Amsterdam Geneeskunde Faculteit, Netherlands, 1918; for many years affiliated with the Tuberculosis Research Laboratory of the Colorado College in Colorado Springs; began active duty as a captain in the medical corps, Army of the United States, in August 1943 and was released from active duty with rank of major in April 1946; died October 18, aged 53, of adenocarcinoma of the colon.

Alvers T. Botts, Decatur, Ill.; Keokuk (Ia.) Medical College, 1897; died September 17, aged 86, of cerebral thrombosis.

Alma Josephine Chapman, York, Neb.; Omaha Medical College, 1897; for many years superintendent of the State Reformatory for Women; died September 7, aged 74, of carcinoma of the breast.

Elliott DeJarnette, Ashland, Va.; University of Virginia Department of Medicine, Charlottesville, 1897; died October 21, aged 73, of heart disease.

Mary Wade Griscom, Philadelphia; Woman's Medical College of Pennsylvania, Philadelphia, 1891; served on the staffs of the Woman's Hospital and the West Philadelphia Hospital for Women and Children; spent many years in China; died November 5, aged 80, of endocarditis.

Thomas James Lamping, Neenah, Wis.; Rush Medical College, Chicago, 1901; member of the Illinois State Medical Society and the American Medical Association; served during World War I; formerly on the staff of the Norwegian American Hospital in Chicago; died October 22, aged 69.

A. S. McCleary, Excelsior Springs, Mo.; Eclectic Medical University, Kansas City, 1904; died October 21, aged 81.

Arthur Bancroft McKinney, Washington, D. C.; Howard University College of Medicine, Washington, 1914; died October 18, aged 58.

George Morris Malkin, Alhambra, Calif.; Louisville (Ky.) Medical College, 1905; for many years affiliated with the county health department; served in the U. S. Naval Reserve during World War I; died September 5, aged 63, of cerebral hemorrhage.

Fred Garrison Markle, Pleasantville, N. Y.; Albany (N. Y.) Medical College, 1897; died in the Northern Westchester Hospital, Mount Kisco, October 9, aged 75.

John Luther Maroon ✠ Santa Ana, Calif.; Vanderbilt University School of Medicine, Nashville, 1912; formerly assistant professor of medicine at the College of Medical Evangelists, Los Angeles; died October 8, aged 72.

Willard Leon Michelson ✠ Springfield, Ill.; Northwestern University Medical School, Chicago, 1940; interned and served a residency at the Cook County Hospital in Chicago; served a residency at the Illinois Eye and Ear Infirmary in Chicago; died October 16, aged 31.

Benjamin Joshua Millard, Mount Carmel, Pa.; Jefferson Medical College of Philadelphia, 1892; died October 3, aged 76, of myocarditis.

Fred Lee Ogilvie, Caruthersville, Mo.; St. Louis University School of Medicine, 1906; member of the American Medical Association; for many years health officer of Pemiscot County; for one term represented Scott County in the state legislature while a resident of Blodgett, where he was member and president of the school board; served during World War I; died in the Southeast Missouri Hospital, Cape Girardeau, October 14, aged 68, of cerebral hemorrhage.

Monroe Pennington, Mount Vernon, Ky.; Louisville Medical College, 1898; member of the American Medical Association; president of the Bank of Mount Vernon; local surgeon for the Louisville and Nashville Railroad Company; died September 27, aged 74, of cerebral hemorrhage.

Ural Albert Vest Presnell ✠ Kennett, Mo.; Barnes Medical College, St. Louis, 1904; served during World War I; part owner and medical superintendent of the Presnell Hospital; died October 3, aged 66.

Jesse Burt Sampsell ✠ Van Wert, Ohio; Ohio Medical University, Columbus, 1903; served as city health officer, as examining physician for the induction center and as a member of the staff of the Miami Hospital in Dayton; died September 21, aged 70, of coronary thrombosis.

John Shaffer Simms, Hollywood, Calif.; Rush Medical College, Chicago, 1911; also a graduate in pharmacy; diplomate of the National Board of Medical Examiners; member of the American Medical Association; served overseas during World War I; past president of the Chamber of Commerce in Bellflower, where he was president of the Rotary Club; served on the staff of the Artesia (Calif.) Hospital; died in the Hollywood-Presbyterian Hospital September 6, aged 63, of arteriosclerosis and coronary occlusion.

Nathaniel Brown Stanton ✠ Plainfield, N. J.; Cornell University Medical College, New York, 1920; fellow of the American College of Surgeons; chief of the emergency medical service of the Plainfield Defense Council during World War II; senior attending surgeon, Muhlenberg Hospital, where he died October 17, aged 53, of cerebral hemorrhage.

William Cowell Stephenson Jr. ✠ Roanoke, Va.; University of Virginia Department of Medicine, Charlottesville, 1929; served during World War II; affiliated with the Roanoke Hospital; died October 2, aged 45.

Ford H. Swetnam, Fairfax, Va.; Georgetown University School of Medicine, Washington, D. C., 1907; Fairfax county medical examiner; at one time mayor of Vienna; member of the board of the National Bank of Fairfax; died in September, aged 62.

Sydney Peyster Waud ✠ Chicago; Northwestern University Medical School, Chicago, 1936; served as a colonel in the medical corps, Army of the United States, during World War II; interned at the Presbyterian Hospital; clinical assistant in medicine at his alma mater; on the staff of the Passavant Memorial Hospital; died October 18, aged 37.

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Foreign Letters

LONDON

(From Our Regular Correspondent)

Nov. 23, 1946.

Progress in Rehabilitation

The rehabilitation of those disabled in the war has received great attention from the government. For this purpose an interdepartmental committee has been formed of representatives of the Ministries of Education, Labor, National Insurance, Pensions and Health. The purpose of the committee is to coordinate the work of the departments responsible for rehabilitation and resettlement and to secure some general supervision over its development and administration. Great progress has been made in the hospitals, the number with all facilities having increased from 48 in 1943 to 204 this year. Measures for dealing with cardiac cases, tuberculosis, deafness, psychoneuroses and the rehabilitation of miners have been taken. Cases of psychiatric disorders have been found the most difficult to handle, and steps are being taken to set up experimental centers.

Modern methods of treatment and rehabilitation at the Ministry of Pensions Hospital have shown that most of the disabled paraplegics can undertake remunerative employment under suitable conditions. The committee was advised that before attempting to set up a special employment scheme for this type of disablement further experience was needed. At two hostels, each accommodating 50 to 70 persons, a plan in which the Ministry of Labor cooperating with regard to training and employment is being tried out.

Since September, 1945 a register of disabled persons has been maintained at all local offices of the Ministry of Labor. On August 19 last there were 628,638 persons on the register. Registration is a condition of eligibility for the employment schemes under the Disabled Persons Employment Act, which makes it obligatory on employers to employ a certain proportion of disabled persons. At present employers of 20 or more persons must employ 3 per cent of disabled persons, and the possibility of increasing this percentage is kept in mind. For the employment and training needs of those unlikely to get employment under ordinary conditions the Minister has set up the Disabled Persons Employment Corporation, which has a program of 50 factories known as "Reemploy Factories." Since April the Ministry of Labor has assumed responsibility for the training of the adult blind.

The End of the White Loaf of Bread

Speaking to the members of the Food Education Society, Sir Jack Drummond, biochemist and official adviser to the Ministry of Food, said that the white loaf had gone, never to return. The present flour extraction rate was a compromise between the highest possible nutritive value and the demands of popular taste. Dark flour was associated with the hardships of war, and the complaints of consumers were mainly psychologic. In June 1940, when the Ministry of Food announced that calcium would be added to flour, hundreds of people complained that the bread was difficult to digest. Many said that the new mixture aggravated arthritis. But in point of fact calcium had not been added at the time of the announcement, because none was available. When it was introduced many months later, without publicity, there was no popular reaction.

Before the war there were no scientific data to show the best level of flour extraction. Government research workers, however, dissected the wheat berry under the microscope and found that the scutellum and outer envelope had high vitamin B and iron content. Milling processes were revised and it was eventually decided that a flour extraction rate of 85 per cent, with its low bran content, had the best nutritive value. It is noteworthy that this abolition of the white loaf is one good result of the great war. It was not brought about because of the dietetic deficiency of the white loaf but because of the need, under the stress of war, to extract more flour from wheat in order to increase the food supply. The task of helping to feed countries impoverished by the war caused the extraction rate of flour to be raised to 90 per cent, but it has now gone back to 85 per cent, while bread rationing continues. The object of returning to 85 per cent is to increase the supply of animal feeding stuffs, so as to help to maintain the winter supply of milk. The prewar extraction rate responsible for the white loaf was 73 per cent. The material extracted from the wheat berry is used by manufacturers of vitamins to produce their expensive and widely advertised articles. Thus the public has the opportunity to recover the removed vitamins at considerable expense!

BRAZIL

(From Our Regular Correspondent)

RIO DE JANEIRO, Oct. 10, 1946.

Hematologic Data of Normal Adult Dog

It seems useful to record, for the sake of comparison with American figures, the results published by Dr. W. O. Cruz, Dr. E. M. da Silva and Dr. R. Pimenta de Mello of the hematologic data of the normal adult dog of Brazil. The authors are members of the division of hematology of the Oswaldo Cruz Institute of Rio de Janeiro, where all the investigations have been performed with the utmost care. For the various determinations, the latest standard technics of the American laboratories have been used. The authors performed the hematologic tests on 135 mongrel adult dogs, 100 males and 35 females. In the results of all the tests statistical significant difference between the two sexes has not been found, which is in accordance with the data of the American dog. The results for the two sexes as a whole and the respective standard errors are as follows: erythrocytes (millions per cubic millimeter) 5.7 ± 0.06; hemoglobin (grams per hundred cubic centimeters) 12.60 ± 0.13; hematocrit (per cent) 42 ± 0.49; volume index or mean corpuscular volume (cubic microns) 74 ± 0.34; hemoglobin index or mean corpuscular hemoglobin (micrograms) 22 ± 0.10; saturation index or mean corpuscular hemoglobin concentration (per cent) 30 ± 0.16. In 42 dogs the blood volume was determined by the dye method, which permitted several important ratios to be figured out. The ratio total blood/body weight was 10.3 per cent $\pm$ 3.3, the ratio hemoglobin/body weight was 10.7 per cent $\pm$ 3.2 and the ratio plasma volume/body weight was 5.9 per cent $\pm$ 1.8. Other tests have been performed on 100 dogs: diameter by Bock's erythrocytometer was 6.9 ± 0.9 micron; the percentage of reticulocytes varied between 0.1 and 1.5; the platelet volume determined by the thrombocytocrit method was 0.80 ± 0.30 per cubic centimeter; the leukocyte count was $12,200 \pm 7,800$.

First Report of Newcastle-Boyd-88 Bacillus in Brazil

Dr. Vera Leite Ribeiro of the Instituto Nacional de Puericultura has published a report about 3 cases of bacillary dysentery from which she was able to isolate Shigella paradysenteriae of the Newcastle-Boyd-88 strain for the first time in Brazil. Many cases of acute dysentery caused by this strain of Shigella have been reported in the United States and in Europe, but only in 1940 was it registered in connection with cases of the disease in South America, by Mormaeche in Uruguay. Since then it has been disclosed that 5.5 per cent of the Shigellae from cases of dysentery in Montevideo are classified in this group. The Shigellae from 1 of Dr. Ribeiro's cases presented a biochemical behavior identical with that described by Clayton and Warren; the other two belonged to the Boyd-88 type. All 3 patients were children a few years of age.

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Correspondence

BRUTALITIES OF NAZI PHYSICIANS

To the Editor:—The editorial "The Brutalities of Nazi Physicians" in the November 23 issue of THE JOURNAL directs attention to one of the most important aspects of the medical interrogations in Germany following the war. As Dr. Ivy found, there was indeed no excess of which some Nazi physicians were not guilty. It was a sickening and disturbing experience to enter such camps as Dachau shortly after they were captured and talk to the men who participated in these crimes. Their repeated defense was that these experiments were all done in the name of science. Dr. Klaus Schilling, the malariologist at Dachau, who was hanged for his part in this work in May 1946, said "What is it if a few people die, if by my work I can save the lives of thousands."

The general scope of these crimes has been amply covered in the editorial, but I question one conclusion which this editorial draws. I speak of the statement that the most serious aspect of the Nazi war crime is the failure of the German medical organizations and societies to express their disapproval or do anything to stop them.

My interrogations of hundreds of German physicians failed to reveal any evidence that they were aware of what was going on in the name of medical science in the concentration camps or that, being aware, they had any power to exercise even such a faint gesture as the voicing of disapproval.

To condemn the German medical profession as a body for failure to act against the avowed policy of the leaders of National Socialism or against some of their colleagues who willingly followed their political leaders in these crimes is to assume that the German organizations had both knowledge of the activities and the power to do something about it. Some information concerning the experiments being done in the concentration camps was released in a medical meeting in Nuremberg in October 1942. Other information seeped out from time to time, but the grumbling reception which these revelations was accorded led the concentration camp physicians to assume an air of secrecy in their activities. Furthermore, it was considered unhealthy to be at all curious about what went on behind the barbed wire of the Nazi concentration camps. German civilians before the war shunned any talk and turned away from seeking any information as to what went on in these places. One was better off not to know.

Physicians in this country without any appreciation of what it means to live under the all seeing eye of a secret police have righteously declared that had they been in Germany, they certainly would have done something about it. And yet it is to be wondered what they might have done had they known that to have spoken out might have meant that their son in the army would be reported "shot by accident" or that their daughter might disappear only to turn up in a brothel or that they themselves might be called on in the dark of the night by the Gestapo. When Heinrich Himmler, the head of the secret polite, declared that he regarded any one who disapproved of these concentration camp experiments as traitors to the Nazi nation, that was sufficient warning to the German medical profession to keep quiet.

No medical group, regardless of how high its ideals, can withstand the impact of the constant propaganda and the threat of violence that is the major characteristic of the police state. Careful consideration should be given to this major political factor when the Association takes its stand on these heinous medical crimes.

CORTEZ F. ENLOE JR., M.D.,
12 East 41st Street,
New York 17.

To the Editor:—In the editorial "The Brutalities of Nazi Physicians" (THE JOURNAL, November 23) reference is made to a Dr. Sigmund Schilling as the most prominent of the brutal experimenters, whose name has been associated with study on the blood.

I wonder if many of your readers will not confuse this person with Dr. Victor Schilling, formerly chief of the First Medical Clinic at the Charité in Berlin. It is to be hoped not only that the guilty will be punished but also that there should be no confusion of identities when such grave crimes as these are being judged.

ROBERT W. BUCK, M.D., Boston.

THE TEACHING OF ALLERGY

To the Editor:—More and more it is recognized with advances in medical knowledge and consequent specialization that additional opportunities must be provided for postgraduate medical education. This need has been especially felt with the release of many physicians from the armed services. Allergy is one specialty in which provision for a broad comprehensive training has been severely limited. At the 1944 meeting of the American Academy of Allergy, Dr. David P. Barr discussed this limitation (The Relationship of Allergy to Medicine, *J. Allergy* **16**:61 [March] 1945). Dr. Barr stated that a total of only thirteen residencies and fellowships were available for training allergists throughout the whole country. He recommended that the training of allergists should be along broad lines in immunology, biochemistry, pediatrics, dermatology and rhinology as well as in allergy. Such a program, he thought, would require about two years of full time training.

A program which has been under way since January 1946 and meets all the requirements set down by Dr. Barr is described in the *Journal of Allergy* **17**:324 (Sept.) 1946.

In the clinical fields, lectures and ward rounds are given throughout the year in internal medicine. Lectures and clinics are given in pediatrics, dermatology, rhinology, ophthalmology, dietetics and psychiatry as related to allergy. The nonclinical subjects in the phases related to allergy are taught by specialists in immunology (lectures and laboratory), botany (lectures, laboratory and field trips), immunochemistry, physiology and pharmacology.

Four research fellowships have been established. The registration in the course is limited to ten physicians. After completion of the first year, those who are interested in research and desire to continue in attendance may do so and register for an advanced degree in the Graduate School.

The value in a medical school of cutting across departmental lines to make use of men trained in related clinical and nonclinical fields is demonstrated in the organization of this course.

A. C. IVY, M.D., Chicago.

THERAPY OF THROMBOSIS AND EMBOLISM

To the Editor:—I have read with interest and with appreciation your editorial entitled "Therapy of Thrombosis and Embolism" appearing in the October 26 issue of THE JOURNAL. Your statement regarding the findings of my associates and myself is correct and we appreciate being quoted in this manner.

It has always been our belief, and we have so stated in both our earlier paper and the one in surgery from which you quoted, that "an ounce of prevention is worth a pound of cure." Why it is that physicians will readily accept preventive measures in infectious and contagious diseases and yet blind themselves to the few simple and easily understood physiologic facts that

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underlie venous stasis as it occurs in the extremities is something I have never been able to understand. Perhaps it is because I am a pathologist and not a clinician. There was a time, before the advent of Dicumarol particularly, when clinicians, locally at least, were willing to listen to the suggestion that it is better to try to prevent thrombosis than to allow phlebothrombosis to occur and then to treat it. It seems to us that the clinical mind is obsessed with the idea that the physician must do something, preferably something that will let the patient know that something is being done, irrespective of the dangers, the cost and, in the case of Dicumarol, the great amount of extra work that is thrown on the laboratory. During the war, and even yet, we who work in laboratories have been and still are hard put to get enough technicians to carry out the necessary procedures. From a laboratory man's point of view, having to make prothrombin time estimations when other means of handling the problem of phlebothrombosis are at hand is distinctly unwelcome.

If certain sentences of the editorial had been italicized or put in boldface type, the editorial would have come much nearer to the truth. For example, "This is combined with forceful, active leg movements from the first day." "Those who are opposed to the anticoagulants state that administration of heparin and Dicumarol poses a threat of serious hemorrhage and that these drugs are not able to affect the clots already formed." "Careful laboratory observations on the plasma prothrombin time preoperatively and after administration of Dicumarol are imperative for the safety of the patient when this drug is used."

WARREN C. HUNTER, M.D., Portland, Ore.

URETHANE IN LEUKEMIA

To the Editor:—Since the report by Edith Paterson and her co-workers (*Lancet* **1**:677 [May 11] 1946) on the remarkable effect of urethane in the treatment of leukemia, the validity of this observation has been confirmed by a number of workers in this country (personal communications) and in our own clinic. The British investigators noted, however, that other forms of malignant neoplasia were not appreciably affected by the drug. In 3 of 13 cases of advanced carcinoma of the breast and in 4 of 11 other forms of malignant disease the tumor masses underwent only temporary diminution in size.

We have recently observed a man aged 44 who in June 1946 observed the generalized appearance of multiple skin tumors which in the next three months increased rapidly in size and number. When he first came under our observation he was covered with hard tender skin nodules which varied in diameter from 0.5 to 3.0 cm. Biopsy revealed a highly anaplastic undifferentiated carcinoma. The site of the primary tumor could not be determined with certainty, but a lesion in a bronchus was suspected. The patient was given urethane orally 3 Gm. daily, as suggested by Dr. Paterson and her group. Within four days the nodules were noticeably softer, and after one week they were definitely smaller by measurement. Within thirty days they had almost entirely disappeared. One tiny lesion remained in the right breast, and another small one was barely palpable in the right thigh. On a maintenance dose of 2 Gm. of urethane daily there has been no evidence of recurrence two months after the onset of treatment. The leukocyte count has not been significantly altered. The general condition of the patient remains good.

The surprising action of this simple nontoxic drug merits wider attention, and our experience suggests that urethane may be of value in certain anaplastic types of metastatic carcinoma.

MORTON J. GOODMAN, M.D.
HOWARD P. LEWIS, M.D.
University of Oregon Medical School,
Portland, Ore.

Medical Examinations and Licensure

COMING EXAMINATIONS AND MEETINGS

NATIONAL BOARD OF MEDICAL EXAMINERS EXAMINING BOARDS IN SPECIALTIES

Examinations of the National Board of Medical Examiners and the Examining Board in Specialties were published in THE JOURNAL, Dec. 21, page 1036.

BOARDS OF MEDICAL EXAMINERS

ALABAMA: *Examination.* Montgomery, Jan. 21-23. Sec., Dr. B. F. Austin, 519 Dexter Ave., Montgomery.

ARIZONA: * Phoenix, January. Sec., Dr. J. H. Patterson, 826 Security Bldg., Phoenix.

ARKANSAS: * *Medical Examination.* June 5-6. Sec., Medical Board of the Arkansas Medical Society, Dr. L. J. Kosminsky, Texarkana. *Eclectic.* Little Rock, June 5. Sec., Dr. C. H. Young, 1415 Main St., Little Rock.

CALIFORNIA: *Examination.* Los Angeles, March 10-13. Sec., Dr. Frederick N. Scatena, 1020 N. St., Sacramento 14.

COLORADO: * Denver, Jan. 7-10. Sec., Dr. J. B. Davis, 831 Republic Bldg., Denver 2.

CONNECTICUT: * *Medical Examination.* Hartford, March 11-12. Sec. to the Board, Dr. Creighton Barker, 258 Church St., New Haven. *Homeopathic.* Derby, March 11. Sec., Dr. J. H. Evans, 1488 Chapel St., New Haven.

DELAWARE: *Examination.* Dover, Jan. 14-16. *Endorsement.* Dover, Jan. 21. Sec., Medical Council of Delaware, Dr. J. S. McDaniel, 229 S. State St., Dover.

GEORGIA: Atlanta and Augusta, June. Sec., State Examining Boards, Mr. R. C. Coleman, 111 State Capitol, Atlanta 3.

HAWAII: Honolulu, Jan. 13-16. Sec., Dr. S. E. Doolittle, 881 S. Hotel St., Honolulu 53.

IDAHO: Boise, Jan. 14. Dir., Bureau of Occupational Licenses, Miss Agnes Barnhart, 355 State Capitol Bldg., Boise.

ILLINOIS: Chicago, Jan. 28-30. Supt. of Registration, Department of Registration & Education, Mr. Philip Harman, Springfield.

INDIANA: *Examination.* Indianapolis, June. Exec. Sec., Board of Medical Registration and Examination, Miss Ruth V. Kirk, 627 K. of P. Bldg., Indianapolis.

MINNESOTA: * Minneapolis, Jan. 21-23. Sec., Dr. J. F. Du Bois, 230 Lowery Medical Arts Bldg., St. Paul 2.

MISSISSIPPI: *Reciprocity.* Jackson, December. Asst. Sec., State Board of Health, Dr. R. N. Whitfield, Jackson 113.

MISSOURI: *Examination:* Kansas City, Jan. 27-29. Exec. Sec., Department of Education, Mr. John A. Hailey, State Capitol Bldg., Jefferson City.

MONTANA: Helena, April 1-2. Sec., Dr. O. G. Klein, First National Bank Bldg., Helena.

NEBRASKA: * *Examination.* Omaha, June 1947. Dir., Bureau of Examining Board, Mr. Oscar F. Humble, State Capitol Bldg., Lincoln.

NEVADA: *Examination.* Carson City, May 5. Sec., Dr. G. H. Ross, 215 N. Carson St., Carson City.

NEW HAMPSHIRE: Concord, March 13. Sec., Board of Registration in Medicine, Dr. John S. Wheeler, 107 State House, Concord.

NEW JERSEY: Trenton, June 17-18. Sec., Dr. E. S. Hallinger, 28 W. State St., Trenton.

NEW MEXICO: * Santa Fe, April 7-8. Sec., Dr. LeGrand Ward, 141 Palace Ave., Santa Fe.

NEW YORK: Albany, Buffalo, New York and Syracuse, Jan. 27-30. Sec., Dr. Jacob L. Lochner, Education Bldg., Albany.

NORTH CAROLINA: *Endorsement.* Raleigh, Jan. 16. Act. Sec., Mrs. L. McNeill, 226 Hillsboro St., Raleigh.

NORTH DAKOTA: Grand Forks, Jan. 7-10. Sec., Dr. G. M. Williamson, 4½ S. Third St., Grand Forks.

OKLAHOMA: * *Reciprocity.* Oklahoma City, Dec. 29-30. Sec., Dr. J. D. Osborn Jr., Frederick.

OREGON: * Portland, Jan. 22-25. Exec. Sec., Miss L. M. Conlee, 608 Failing Bldg., Portland 4.

PENNSYLVANIA: Philadelphia and Pittsburgh, July. Acting Sec., Bureau of Professional Licensing, Department of Public Instruction, Mrs. M. G. Steiner, 351 Education Bldg., Harrisburg.

RHODE ISLAND: * Providence, Jan. 2-3. Chief, Division of Examiners, Mr. Thomas B. Casey, 366 State Office Bldg., Providence.

SOUTH DAKOTA: * Pierre, Jan. 21-22. Sec., Dr. Gilbert Cottam, State Capitol Bldg., Pierre.

TEXAS: *Examination.* Galveston, Feb. 20-22. Sec., Dr. T. J. Crowe, 910 Texas Bank Bldg., Dallas 2.

VERMONT: *Examination.* Burlington, Jan. 31-Feb. 1. Sec., Board of Medical Registration, Dr. F. J. Lawliss, Richford.

WASHINGTON: *Examination.* Seattle, January 1947. Sec., Mr. Nelson Vaughn, Olympia.

WEST VIRGINIA: Charleston, Jan. 6-8. Commissioner, Public Health Council, Dr. N. H. Dyer, State Capitol, Charleston 5.

WYOMING: Cheyenne, Feb. 3. Sec., Dr. G. M. Anderson, Capitol Bldg., Cheyenne.

* Basic Science Certificate required.

BOARDS OF EXAMINERS IN THE BASIC SCIENCES

CONNECTICUT: Feb. 8. Address State Board of Healing Arts, 250 Church St., New Haven.

DISTRICT OF COLUMBIA: Washington, April 21-22. Sec., Commission on Licensure, Dr. G. C. Ruhland, 6150 E. Municipal Bldg., Washington 1.

FLORIDA: May 31. Sec., Dr. M. W. Emmel, University of Florida, Gainesville.

IOWA: Des Moines, Jan. 14. Corresponding Sec., Division of Licensure & Registration, Mr. H. W. Grefe, Capitol Bldg., Des Moines 19.

MICHIGAN: Ann Arbor and Detroit, Jan. 10-11. Sec., Miss Eloise LeBeau, 101 N. Walnut St., Lansing 15.

MINNESOTA: Minneapolis, Jan. 7-8. Sec., Dr. Raymond N. Bieter, 105 Millard Hall, University of Minnesota, Minneapolis 14.

NEBRASKA: Omaha, Jan. 14-15. Dir., Bureau of Examining Boards, Mr. Oscar F. Humble, 1009 State Capitol Bldg., Lincoln 9.

OREGON: Portland, March 1. Sec., Board of Higher Education, Mr. C. D. Byrne, University of Oregon, Eugene.

RHODE ISLAND: Providence, Feb. 12. Chief, Division of Examiners, Mr. Thomas B. Casey, 366 State Office Bldg., Providence.

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Bureau of Legal Medicine and Legislation

MEDICOLEGAL ABSTRACTS

Medical Practice Acts: Board's Inherent Right to Revoke License Procured Through Fraud.—The plaintiff filed suit for an injunction to restrain the defendant State Board of Medical Education and Licensure from conducting a hearing for the revocation of his license to practice medicine and surgery. From a judgment for the defendant, the plaintiff appealed to the Supreme Court of Pennsylvania.

The plaintiff was licensed to practice medicine and surgery in Pennsylvania in 1910 pursuant to the provisions of a law passed in 1893 and still in force. He practiced his profession in Pennsylvania until 1913, when he left to practice in another state. In 1932 he returned to Pennsylvania and resumed the practice of his profession until June 30, 1944, when the state board issued a citation directing him to appear at a hearing before the board to answer charges that he had obtained his license to practice medicine through fraud, misrepresentation and deception. The present suit was then filed to question the authority of the state board to proceed with such hearing.

The first comprehensive legislation establishing a separate medical bureau and regulating the issuance and revocation of licenses to practice medicine and surgery was the act of June 3, 1911. The power of the Bureau of Medical Education and Licensure to revoke licenses under section 12 of that act was then believed to be restricted only to those licenses issued subsequent to June 3, 1911. An amendment to section 12 of the 1911 act was enacted in 1917 by which it was provided that the board had authority to revoke the license of "Any person who is licensed to practice medicine and surgery or any of its branches in the Commonwealth of Pennsylvania . . ."

The plaintiff first argued that the 1917 amendment was not valid in that the title of that act was in violation of article III, section 3, of the Pennsylvania constitution. The Supreme Court said that the title of the 1917 act recited that its purpose was "To further amend an act, approved the third day of June, one thousand nine hundred and eleven . . . by providing for further instruction prior to examination for licensure, by clarifying sections five (5) and twelve (12)." The narrow argument of the plaintiff is that the word "clarifying" does not give notice that section 12 of the act was amended to apply to physicians licensed prior to 1911. It is clear, said the Supreme Court, that a title which mentions that the act is amendatory, recites the particular prior acts it is designed to amend and further specifies the sections of the prior acts involved puts a person of a reasonably inquiring state of mind on notice of the subject matter of the act and the reader to further inquiry. That is all, concluded the court, that is required by article III, section 3, of the constitution. The stated intention of the legislature in passing the 1911 act and its amendments, the court continued, was to establish a complete system of licensing and regulation of physicians and surgeons. The only purpose of the amendment of section 12 of the act of 1917 was to bring within the jurisdiction of the board those licensed prior to the passage of this legislation. If it is to be said that there is a retroactive effect to these statutes, it can also be said that this was manifestly and clearly intended by the legislature by the very words of section 12 of the 1917 act and by the broad, general purpose of this legislation to bring all physicians and surgeons under the uniform operation of a single licensing and regulatory system. The legislative intent is too clear to require the use of rules of statutory construction.

The plaintiff also questions the authority of the board to revoke a license on the ground of fraud or misrepresentation where the statutory authority under which it acts does not enumerate these as grounds for revocation. While it is true, said the court, that such legislation is penal in nature and must therefore be strictly construed, it is also the general rule that, where the license should never have been granted for reasons such as fraud or forgery, the licensing authority has the inherent power to revoke it. The appellate courts of this state have not passed on this question, the Supreme Court pointed out. Respectable opinion, however, supports the principle that where a license, such as this, was procured by fraud, it may be revoked by the licensing authority regardless of the fact that fraud is not specified as a ground for revocation in the statute. By the mere fact that he was once issued a license and practiced under it, the plaintiff did not thereby acquire such vested right which would prevent the board from thereafter revoking it for cause.

Nor is the defense of laches, the final argument raised by the plaintiff, properly raised at this time, said the Supreme Court. This defense is based on the ground that a long time has elapsed since the original license was issued to the plaintiff and that the records on which he must rely to defend are now unavailable. Laches, the court concluded, is not to be imputed by the mere passage of time but must be determined after all the circumstances of the case are developed. Such is not the case here, for no hearing has been had on the merits. The record is devoid of prejudice to the plaintiff, which is a necessary element for the doctrine of laches to be applied. Accordingly the judgment in favor of the defendant board was affirmed and the appeal dismissed.—*Schireson v. Shafer, 47 A. (2d) 665 (Pa., 1946).*

Malpractice: Skill and Care Required of Dentists in Extracting Tooth.—The plaintiff sued to recover damages for the alleged negligence on the part of the defendant dentist in extracting one of her teeth and in the subsequent treatment rendered. From a judgment of nonsuit entered at the close of the plaintiff's evidence, the plaintiff appealed to the Supreme Court of North Carolina.

The plaintiff went to the office of the defendant dentist and told him she had a tooth she wanted pulled. She asked the defendant to be careful since he had extracted a tooth for her about a year before and "had broken it off." Defendant deadened the surrounding tissue with novocaine but in proceeding to extract the upper left bicuspid it broke off even with the gums. He succeeded in removing two fragments, however, and told the plaintiff to return to the office if her jaw continued to hurt her. Two days later the defendant was notified that the plaintiff's jaw was greatly swollen, looked red and was "running pus." He sent a prescription which was filled and taken without beneficial results. In about a week the plaintiff returned to the defendant's office, and his nurse packed her jaw and sent her home. Continuing to grow worse, the plaintiff again returned to the defendant's office and stated that she thought there was something in her jaw and suggested that an x-ray be taken. The defendant's brother assured her that there was nothing in the jaw and that an x-ray would only be a waste of money. The nurse again packed the jaw. When the plaintiff returned for the third time the defendant took an x-ray. The nurse developed it and said "There is nothing in it." Finally the plaintiff went to another dentist, who examined her swollen jaw, took another x-ray and removed "a little particle of the end of a root of tooth" and "a lot of little dead bone."

Viewing this evidence, said the court, with that degree of liberality required on demurrer, we think the permissible inferences are such as to make the issue of liability one for the jury. It is true that there is no allegation of incompetence on the part of the defendant to practice his profession. It is alleged, however, (1) that the defendant omitted to use reasonable care and diligence in the practice of his art or (2) that he failed to exercise his best judgment in the treatment of the case. Either allegation, said the court, if supported by competent evidence, suffices to carry the case to the jury on the issue of negligence. In the circumstances here disclosed, it is contended that reasonable foresight would have called for more attention and better care on the part of the defendant in the treatment of plaintiff's case. He was notified on three or four occasions and over a considerable length of time that plaintiff's jaw was not healing properly; that the constant and growing pain indicated to the plaintiff, and should have indicated to the defendant, the presence of some deleterious substance; that a proper examination or diagnosis would have disclosed, and did disclose to another dentist, the presence of harmful bacteria. These contentions, the court concluded, find enough support in the evidence to raise an issue of due care. Accordingly the judgment of nonsuit was reversed.—*Love v. Zimmerman, 38 S. E. (2d) 220 (N. C., 1946).*

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Current Medical Literature

AMERICAN

The Association library lends periodicals to members of the Association and to individual subscribers in continental United States and Canada for a period of three days. Three journals may be borrowed at a time. Periodicals are available from 1936 to date. Requests for issues of earlier date cannot be filled. Requests should be accompanied with stamps to cover postage (6 cents if one and 18 cents if three periodicals are requested). Periodicals published by the American Medical Association are not available for lending but can be supplied on purchase order. Reprints as a rule are the property of authors and can be obtained for permanent possession only from them.

Titles marked with an asterisk (*) are abstracted below.

American J. Obstetrics and Gynecology, St. Louis

52:349-528 (Sept.) 1946. **Partial Index**

Fetal Mortality in Breech Delivery. W. J. Dieckmann.—p. 349.
Maternal Obstetric Paralysis. J. T. Cole.—p. 372.
Anatomic Peculiarities of Human Umbilical Cord and Their Clinical Significance. Mary Spivack.—p. 387.
Composition of Human Placenta: I. Proximate Composition. J. P. Pratt, Mildred Kaucher, A. J. Richards, H. H. Williams and Icie G. Macy.—p. 402.
Treatment of Psychogynecic Disorders by Hypnoanalysis. W. S. Kroger. —p. 409.
Abnormal Presentations Among Malformed Infants, with Suggestions Concerning the Etiology. R. L. Young.—p. 419.
*High Protein, Low Caloric Diet for Prevention of Toxemia of Pregnancy. R. Luikart.—p. 428.
Review of 100 Cases of Ovarian Cancer. E. V. Helsel.—p. 435.
Observations on the Rh Factor in Pregnancy, C. H. Ingram.—p. 440.
Hemolytic Disease Associated with the Rh Factor in Twin Pregnancies. E. A. Conti and J. W. Glenn.—p. 446.
Seven Year History in Early Cervical Cancer. H. C. Taylor and H. B. Guyer.—p. 451.
Retroperitoneal Tumors Simulating Genital Tract Neoplasms. W. B. Stromme and H. J. Stander.—p. 456.
Torsion of Adnexal Tumors and Its Relation to Surgical Emergency. M. R. Kelberg and J. H. Randall.—p. 464.
*Sickle Cell Anemia in Pregnancy: Report of Case with Autopsy. R. W. Noyes.—p. 469.
Multiple Primary Carcinomas: S. L. Siegler and L. M. Silverstein. —p. 474.
*Seesaw Resuscitator for Treatment of Asphyxia in Newborn. R. S. Millen and J. Davies.—p. 508.

Diet to Prevent Toxemia of Pregnancy.—Luikart studied the effects on 1,000 pregnant women of a regimen of rigid weight control without interfering with adequate nutrition. The immediate objective was restriction of the total increase of weight to 16 pounds or less during pregnancy, and a maximum of 2 pounds in any one month. All the patients were within normal weight range when first seen. A gain of more than a pound in two weeks calls for reduction, not in the proteins and cooked vegetables, but in the quantity of such foods as ice cream, candy, pastries, cereals, macaroni, cheese, corn, potatoes and bread. The 1,000 patients whose weight was controlled by a restricted diet did not develop toxemia, preeclampsia or eclampsia. Maternal deaths did not occur. Patients following a prescribed diet high in protein have less anemia, less edema and less tendency to develop toxemia or eclampsia. The fetal mortality rate in this series was one-sixth the fetal mortality of an uncontrolled group. Large babies were not observed.

Sickle Cell Anemia in Pregnancy.—A multiparous Negro woman aged 32, in whom preeclampsia and sickle cell anemia were detected during the seventh month of pregnancy, failed to respond to conservative therapy and died following induction of labor. Noyes stresses that obstetricians practicing among Negroes should be familiar with the clinical picture of the disease and be prepared for an increased tendency for thrombosis and liability to fatal sepsis. In order that the diagnosis may be made before the terminal stage, the blood of all Negro mothers, or at least those showing a tendency toward anemia, should be allowed to stand in a sealed preparation for a few hours and examined for "sickling."

Seesaw Resuscitator for Asphyxia in the Newborn.—Millen and Davies used the seesaw method described by Eve (THE JOURNAL, April 1, 1944, p. 964) in asphyxia of a premature infant. In this method the position of the body is alternated frequently by rocking on a trestle, so as to allow the weight of the liver and abdominal contents to drop downward and thus pull air into the lungs when the head is raised and the feet lowered, and the reverse to take place, causing expulsion of air from the lungs when the head is lowered and the feet raised. The child's head was lowered, and immediately the familiar thick mucous plug was expelled through the child's nostrils. Alternate rocking of the child transferred and removed the weight of the abdominal viscera to the diaphragm and thereby established a nontraumatic pulmonary ventilation.

Canadian Medical Association Journal, Montreal

55:327-424 (Oct.) 1946

Effect of Antenatal Conditions on Newborn Child. L. G. Parsons. —p. 327.
Is Amebiasis a Medical Problem in Canada? M. J. Miller.—p. 336.
Treatment of Some Surgical Complications of Amebiasis. D. L. C. Bingham.—p. 341.
Role of Emotions in Production of Cardiovascular Disturbances. G. F. Strong.—p. 344.
Carcinoma of Bladder. R. H. Flocks.—p. 348.
Combined Use of Sodium Pentothal Intocostrin (Curare) Nitrous Oxide. R. T. Knight.—p. 356.
Use of Antballan in Dermatology. L. P. Ereaux and G. E. Craig. —p. 361.
Role of General Practitioner in Diagnosis of Glaucoma. A. J. Elliot. —p. 363.
Surgical Treatment of Cancer of Larynx. H. McCart.—p. 365.
Tuberculosis in Naval Service from 1930 to 1945 (Inclusive). G. Jarry, A. Richardson and W. V. Maynard.—p. 368.
Enuresis. C. B. Stewart.—p. 370.
Chronic Nonspecific Thyroiditis. C. G. Hori.—p. 372.

Delaware State Medical Journal, Wilmington

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Increase in Age Group in Tuberculosis. L. D. Phillips.—p. 195.
Integrated Approach to Cerebral Palsy. Eunice Usher.—p. 196.
Rehabilitation of Speech for Crippled Children. Marian L. Gilmore. —p. 199.
Child Health—The Brightest Chapter. C. A. Marshall.—p. 201.
Nursing Activities. Mary M. Klaes.—p. 203.
Sanitary "Needs" Survey of Delaware. R. C. Beckett.—p. 204.
Laboratory Comments. R. D. Herdman.—p. 212.
Medical Treatment of High Blood Pressure. J. Q. Griffith Jr.—p. 215.

Florida Medical Association Journal, Jacksonville

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Peripheral Vascular Disease. G. D. Lilly.—p. 141.
Origin and Progress of Florida Radiological Society. J. A. Pines. —p. 144.

33:171-222 (Oct.) 1946

Treatment of Sacroiliac Sprain by Manipulation: Report of 146 Cases. A. M. Bidwell.—p. 193.
Ligation of Inferior Vena Cava as Therapeutic Procedure. W. C. Rentz. —p. 199.

Gastroenterology, Baltimore

7:285-392 (Sept.) 1946

Gastroscopy and Its Relationship to Roentgenology in Diagnosis of Carcinoma of Stomach. H. J. Moersch and B. R. Kirklin.—p. 285.
Backache Due to Intra-Abdominal Disease. H. J. Tumen and J. C. Yaskin.—p. 294.
Note on Bacteriologic and Parasitic Studies of Intestinal Contents of Patients with Sprue. F. Milanes, A. Curbelo, A. Rodriguez and others.—p. 306.
Peptic Ulcer of Esophagus: Report of Patient with Ten Year Follow-Up. D. R. Morton and A. Brunschwig.—p. 314.
Hematemesis: Study of Underlying Causes. H. L. Thompson, J. M. Oyster, J. B. Heid and F. M. Morgan.—p. 320.
*Gastric Secretion in Duodenal Ulcer in Remission—Response to Caffeine Test Meal. V. H. Musick, H. T. Avey, H. C. Hopps and A. A. Hellbaum.—p. 332.
Vascular Changes in Mucosa in Experimental Nutritional Gastritis. B. N. Berg.—p. 340.

Gastric Secretion in Duodenal Ulcer in Remission.—Musick and his associates studied gastric secretion following the caffeine test meal in 20 patients with duodenal ulcer in remission and compared these data with the responses in 25 patients with active duodenal ulcers and in 10 healthy persons. The average total amount of free hydrochloric acid secreted normally during the two hour test period was 363 mg., while the average secretion of those patients with ulcer in remission was 631 mg. (an increase of 174 per cent). In patients with active duodenal ulcer the amount of acid secreted averaged 957 mg., or 264 per cent over that of the normal persons. The increased concentration of free acid following the caffeine stimulus appeared to be the important factor in relation to tissue destruction. The average concentration of free hydro-

chloric acid secreted normally during the two hour test period was 86 mg. per hundred cubic centimeters, while the average secretion of patients with ulcer in remission was 162 mg. per hundred cubic centimeters (an increase of 88 per cent). In patients with active duodenal ulcer the concentration of acid secreted averaged 214 mg. per hundred cubic centimeters, or 149 per cent over that of the normal persons. Patients presenting high prolonged secretory responses in the active stage of duodenal ulcer showed relatively high and prolonged secretory curves when tested in remission. Conversely, those who presented relatively short secretory curves during the active stage of duodenal ulcer responded with lower and less prolonged curves when tested in remission.

Illinois Medical Journal, Chicago

90:145-200 (Sept.) 1946

War and Disease. R. H. Major.—p. 162.
*Vitallium Plates Used in Repair of Large Hernias. R. W. McNealy and J. A. Glassman.—p. 170.
Recent Developments in Treatment of Hypertension. E. W. Cannady. —p. 173.
Treatment of Fractures of Superior and Inferior Maxilla. W. A. McNichols.—p. 179.
Recovery From Primary Friedländer Pneumonia (Type B) on Therapy with Sulfadiazine and Penicillin. N. T. Welford.—p. 185.
A Rorschach Study of Symptomatic Schizophrenia Following Brain Trauma. J. L. Endacott.—p. 187.
Human Ornithosis: Report of Case Treated with Penicillin. T. Kirkwood.—p. 193.

Vitallium Plates in Repair of Large Hernias.—Since certain large hernias of long standing are difficult or impossible to repair by the usual reconstructive suture methods or by autogenous fascial grafts, McNealy and Glassman employed in certain instances the implantation of a mechanical inert prosthesis to replace the defective parietes and act as a scaffold about which new tissue might grow. It was the inert property that led the writers to make use of vitallium in anterior abdominal wall reconstructions. The metal plate is so constructed that the spermatic cord passes through an opening which offers protection to the region of the internal ring. The plate is also provided with perforations through which sutures can be inserted to hold it securely in place. Its position is such that it does not interfere with flexion of the thigh on the abdomen or with torsion of the pelvis. Vitallium plates can be applied also in the repair of umbilical hernias and in other types of ventral and postoperative hernias. This method of hernial repair is particularly useful in the treatment of elderly persons.

Indiana State Medical Assn. Journal, Indianapolis

39:425-476 (Sept.) 1946

Tumors of Nose and Throat. F. A. Figi.—p. 425.
Practical Application of Rh Factor in Congenital Hemolytic Anemia of Newborn (Erythroblastosis Fetalis), Habitual Abortion and Blood Transfusions. J. L. Haymond and A. S. Giordano.—p. 429.
Reconstructive Surgery Following Treatment of Osteomyelitis by Saucerization and Early Skin Grafting. J. A. McClintock.—p. 436.
Anesthetic Progress. J. M. Whitehead.—p. 440.
Ambulatory Treatment of Phlebitis. C. W. Day.—p. 442.
Thiourea and Its Derivative Thiouracil as Goitrogen. I. E. Brenner. —p. 445.

Journal-Lancet, Minneapolis

66:319-350 (Oct.) 1946

Diet and the Liver. H. O. Drew.—p. 319.
Anesthesia in General Practice. R. T. Knight.—p. 323.
Thiouracil in Management of Hyperthyroidism. R. L. Egan.—p. 326.
Immunology of Poliomyelitis. C. A. Evans.—p. 328.

Journal of Nat. Cancer Inst., Washington, D. C.

7:1-46 (Aug.) 1946

Neutral Beta Glycerophosphatase Activity in Normal and Neoplastic Tissues. J. P. Greenstein and Florence M. Leuthardt.—p. 1.
Survey of Hypnotics in General with Regard to Pulmonary Tumor Induction in Mice. C. D. Larsen, with technical assistance of P. B. Rhoads Jr. and Lucille L. Weed.—p. 5.
Enzymatic Desamination and Dephosphorylation of Ribosenucleic and Desoxyribosenucleic Acids. J. P. Greenstein, C. E. Carter, H. W. Chalkley and Florence M. Leuthardt.—p. 9.
Studies on Enzymatic Degradation of Nucleic Acids. C. E. Carter and J. P. Greenstein.—p. 29.

Military Surgeon, Washington, D. C.

99:273-360 (Oct.) 1946

Neuroectodermal Tumors Containing Neoplastic Neuronal Elements: Ganglioneuroma, Spongioneuroblastoma and Glioneuroma, with Clinicopathologic Report of 11 Cases, and Discussion of their Origin and Classification. H. Kuhlenbeck and W. Haymaker.—p. 273.
Naval and Marine Corps Casualties in Wars of United States. L. H. Roddis.—p. 305.
*Intractable Amebiasis—A Warning, with Report of Case. H. A. Monat and J. E. Hertner.—p. 310.
Bacteriologic Study of Resistance of Organisms Isolated from Cases of Nonspecific Urethritis to Three Chemotherapeutic Agents. A. M. Weckstein, with the technical assistance of S. H. Rasmussen.—p. 312.

Intractable Amebiasis.—In view of the prospective increase of amebiasis in the United States, Monat and Hertner issue a warning that cases which show dramatic improvement after one course of antiamebic treatment should be forewarned that a relapse is possible. A combined treatment of emetine parenterally and diodoquin simultaneously in early cases of amebiasis (ten days of emetine 1 grain [0.06 Gm.] and fifteen days of diodoquin 3½ grains [0.2 Gm.] four times a day before meals) and in chronic cases emetine bismuth iodide 2 grains (0.13 Gm.) at bedtime for ten days, diodoquin 3½ grains for fifteen days four times a day, vioform intraduodenally and carbarsone 1 per cent retention enemas twice weekly will insure clearing up amebiasis in the majority of cases. At least twenty to thirty stools should be collected between treatments before a patient is pronounced clear of the infection. A case is presented which suggests that there are cases which are resistant to continued and combined treatment.

Occupational Medicine, Chicago

2:183-284 (Sept.) 1946

Psychoneurosis and Industry. W. F. Schaller.—p. 183.
Significance of Industrial Cancer in Problem of Cancer. W. C. Hueper —p. 190.
Rehabilitation of Sick and Injured. R. L. Diveley.—p. 201.
Tuberculosis Control in Industry: Results from 1941 to 1945. C. R. Allison.—p. 207.
Sprain or Momentary Dislocation of Talus? R. R. De Nicola.—p. 214.
Treatment of Wounds. J. J. Moorhead.—p. 219.
Values and Problems in Industrial Recreation. F. R. Eastwood.—p. 226.

Philippine Medical Association Journal, Manila

22:191-222 (May) 1946

Philippine Medical Association: Retrospect and Prospect; Presidential Address. V. de Dios.—p. 193.
Rh Factor: Incidence Among Filipinos. C. P. Manahan and M. Andaya. —p. 199.
Penicillin in Treatment of Gonorrhea and Syphilis. A. F. Brand.—p. 203.
Bilateral Orchiectomy in Cancer of Prostate. L. F. Torres Jr. and P. Morales.—p. 207.

Virginia Medical Monthly, Richmond

73:393-436 (Sept.) 1946

Annual Meeting (Walter Reed Night), Section on History of Medicine, March 12, 1946. J. H. Smith.—p. 393.
Glimpse at Development of Immunology and Allergy in Light of Contribution of Six Nobel Prize Winners: Von Behring, Richet, Bordet, Metchnikoff, Landsteiner, Koch. W. B. Blanton.—p. 395.
Historical Aspects of Infectious Diseases. K. Nelson.—p. 398.
Dr. William S. Halsted. H. J. Warthen Jr.—p. 403.
Making A Correct Diagnosis: Its Importance and Problems. M. Edmunds.—p. 408.
Review of 129 Consecutive Cases of Tuberculosis Treated with Pneumothorax Over Ten Year Period. T. N. Hunnicutt Jr.—p. 410.

Western J. Surg., Obst. & Gynecology, Portland, Ore.

54:341-378 (Sept.) 1946

Gastrojejunal Ulcer Following Gastric Resection. J. W. Baker.—p. 341.
Spinal Anesthesia in Vaginal Deliveries: Report of 1,000 Inductions. E. W. Cartwright and W. C. Rogers.—p. 346.
Transthoracic Operation for Megesophagus. G. W. Nagel and J. F. Menke.—p. 352.

54:379-410 (Oct.) 1946

Hypoxemia of Fetus. H. F. Traut.—p. 379.
Duodenal Septum. O. F. Lamson.—p. 384.
Meralgia Paresthetica: New Causal Observations. E. W. Mack.—p. 390.
Protein Depletion in Pregnancy Toxemia. H. Spitzer.—p. 392.
Electrotherapy of Levator Muscle of Anus (Levator Ani) During Postpartum Period and in Some Gynecologic Conditions. H. Vignes. —p. 394.
Further Observations on Prostigmine in Delayed Menstruation and Pregnancy. D. Parrella.—p. 397.

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FOREIGN

An asterisk (*) before a title indicates that the article is abstracted below. Single case reports and trials of new drugs are usually omitted.

Australian and New Zealand J. Surgery, Sydney

15:235-312 (April) 1946

Surgical Lessons of Last Five Years of War and Their Application to Postwar Surgical Practice. V. Hurley.—p. 235.
Some Observations on Head Injuries and Their Complications. L. Rogers.—p. 249.
Abdominal Injuries in Second New Zealand Expeditionary Force During Italian Campaign. T. D. M. Stout.—p. 253.
*Anticoagulant Effect of Spleen. E. R. Trethewie.—p. 286.
Influence of Hind Legs and Pelvis on Blood Coagulation. E. R. Trethewie.—p. 292.
Pulmonary Hydatid Disease: Sign of Carpelote. J. A. Jenkins.—p. 296.
Resection of Bladder Neck in Female, with Report of Case. B. Melville. —p. 299.

Anticoagulant Effect of Spleen.—Trethewie describes experiments on dogs which demonstrate that, when diluted heparinized blood is perfused through the spleen, the fluid develops increased anticoagulant activity, and this was found to be unassociated with alterations in the number of platelets in the fluid, heparin or the prothrombin content. It seems likely that there is some anticoagulant material operating, as has been shown to be the case with the liver.

British Heart Journal, London

8:115-170 (July) 1946

Action of Magnesium on Heart, P. Szekely.—p. 115.
Ruptured Congenital Aneurysm of Posterior Sinus of Valsalva. R. N. Herson and M. Symons.—p. 125.
Healed Dissecting Aneurysm. M. Cassidy and J. Pinniger.—p. 130.
Silent Dissection of Aorta. J. Hoskin and Frances Gardner.—p. 141.
Genesis of Normal Electrocardiogram. A. Hill.—p. 147.
Heart Vector and Leads. H. C. Burger and J. B. Van Milaan. —p. 157.
Heart in Sternal Depression. W. Evans.—p. 162.

British Journal of Ophthalmology, London

30:501-572 (Sept.) 1946

Nineteenth Century Provincial Eye Hospitals, with Special Reference to Those no Longer Extant. A. Sorsby.—p. 501.
Bilateral Symmetrical Cystic Detachment of Retina. H. B. Stallard. —p. 547.
Pterygium. Its Nature and New Line of Treatment. S. Kamel.—p. 549.

Lancet, London

2:477-512 (Oct. 5) 1946

Conducing to Cure: Social Psychiatry in Treatment of Neurosyphilis by Induced Malaria. M. Whelen and M. H. Bree.—p. 477.
Use of Reassurance. T. G. Armstrong.—p. 480.
*Post-Hepatitis Syndrome. Sheila Sherlock and V. Walshe.—p. 482.
Pathology of Postanal Pilonidal Sinus: Its Bearing on Treatment. D. H. Patey and R. W. Scarff.—p. 484.
Nicotinamide Methochloride Estimations in Sprue and Amebiasis. J. W. Paulley and G. J. Aitken.—p. 486.
Relations of Steroid Hormones and Anhydro-Hydroxy-Progesterone to Fibromatosis. R. Iglesias and A. Lipschutz.—p. 488.
Remedial Correction of Valgus Foot Strain by Foot Pronation Exercise. E. T. Bailey and B. S. Harrens.—p. 490.

Post-Hepatitis Syndrome.—Sherlock and Walshe studied a group of 20 soldiers in whom symptoms and usually an enlarged liver have remained after clinical recovery from acute hepatitis. Serum bilirubin, phosphatase and differential protein estimations, the colloidal gold reaction, the intravenous hippuric acid test and the sulfobromophthalein test showed no abnormalities. There was an occasional rise in the serum cholesterol level. Hepatic sections obtained by aspiration biopsy were usually normal. In some sections slight fatty change in the liver cells and occasional scarring in the portal tracts could be seen. No difference was found between these results and those obtained in subjects who had recovered from acute hepatitis and were now free from symptoms. The possible psychogenic basis of the symptoms is discussed. The palpable liver seems due to downward displacement of the liver edge rather than to enlargement. The value of aspiration liver biopsy in the differentiation of this syndrome from post-hepatitis cirrhosis is emphasized.

Medical Journal of Australia, Sydney

2:217-252 (Aug. 17) 1946

*Studies of Maternal and Infantile Blood Factor Relationships. Lucy M. Bryce, Rachel Jakobowicz and Norma McArthur.—p. 217.
Tuberculosis in Pregnancy. W. L. Calov.—p. 224.
Pulmonary Tuberculosis in Pregnancy. T. D. Hughes.—p. 230.
Burning Feet Syndrome: Observations of Cases Among Prisoners of War in Manchuria. D. J. Brennan.—p. 232.
*Dangerous Blood Donors. G. A. Kelsall and D. Nicholas.—p. 234.

Maternal and Infantile Blood Factor Relationships.—Bryce and her associates made a survey of 850 women attending the antepartum clinic of the Queen Victoria Hospital in Melbourne. Examination of the blood of both mother and child revealed that the Rh factor is important in the production of hemolytic disease of the newborn. Rh incompatibility is related to fetal abnormalities. It appears that A, B, O incompatibility may be a cause of hemolytic disease, especially the milder manifestations such as late anemia, since in all cases in which these manifestations occurred there was a rise in the isoagglutinin titer in the maternal serum and because in the large number of cases (595) in which complete compatibility between the blood of the mother and that of the child existed the possible manifestations of hemolytic disease consisted of only 2 doubtful cases of icterus gravis. There is no correlation between the anti-Rh titer of the maternal serum and the severity of hemolytic disease in the child. The isoagglutinin titer in the maternal serum early in pregnancy is not significantly higher in those cases in which there is a possibility of immunization by the fetus than it is in those in which the mother and child belong to compatible blood groups. At or shortly after delivery the titer of maternal isoagglutinin corresponding to the infant's A or B factor may rise. This rise appears to be associated in most cases with the secretor state in the infant. In other series of women there was a significantly higher incidence of prematurity, stillbirths and icterus gravis neonatorum among the Rh-negative women.

Dangerous Blood Donors.—Kelsall and Nicholas stress that all parous women and all persons who have themselves been the recipient of a blood transfusion should be regarded as potentially dangerous donors. If blood of such persons is to be used for transfusion purposes it should be examined for isoantibodies. It is particularly important when giving transfusions to infants suffering from hemolytic disease of the newborn that the donor's serum be examined for abnormal antibodies before it is administered. Conversely, if the recipient of a blood transfusion is a parous woman or has received a transfusion at an interval longer than a week previously, the cross typing test should be performed at 4 C., 20 C. and 37 C. for one hour. When, from the previous history, the blood of either the donor or the recipient is suspected of containing isoantibodies, and if these cannot be detected by the usual agglutinating technic, one or more of the sensitive methods should be employed.

2:253-288 (Aug. 24) 1946

*Tick Typhus in North Queensland. R. Andrew, J. M. Bonnin and S. Williams.—p. 253.
North Queensland Tick Typhus: Comparative Study of Rickettsia with that of Murine Typhus. J. F. Funder and A. V. Jackson.—p. 258.
Id.: Studies of Etiologic Agent and Its Relation to Other Rickettsial Diseases. H. Plotz, J. E. Smadel, B. L. Bennett, R. L. Reagan and M. J. Snyder.—p. 263.
Alcohol. C. C. McKellar.—p. 268.
Alcoholism. S. J. Minogue.—p. 271.
Reproductions of Radiographs by Solarization. D. G. Maitland.—p. 273.

2:289-324 (Aug. 31) 1946

Clinical and Pathologic Features of Dysenteries. R. Andrew.—p. 289.

2:325-360 (Sept. 7) 1946

Interstitial Neuritis and Pressure Theory of Pain: Critical Review and Reflex Hypothesis. M. Kelly.—p. 325.
Influence of Anesthetics on Content of Deaminating Enzyme in Human Plasma. E. R. Trethewie.—p. 334.
Report on Psychopathic States of Australian Imperial Force in Malayan Campaign. C. R. Boyce.—p. 339.
Some Problems of Backache and Sciatica. L. Lindon.—p. 345.

Tick Typhus in North Queensland.—Andrew and his associates describe a North Queensland tick typhus which is probably transmitted by the adult and also possibly by the larval tick of Ixodes holocyclus. There is an incubation period of seven to ten days followed by the development of an eschar,

enlarged lymph nodes, malaise, headache, fever and a rash. The disease is mild, runs a course of approximately a week and subsides by lysis. There are no complications or sequelae. The Weil-Felix test produces agglutination with Bacillus proteus OX19 and in some cases with Bacillus proteus OX2. Bacillus proteus OXK is not agglutinated. In murine typhus there is no eschar and the lymph nodes are seldom involved. Scrub typhus has many features in common with tick typhus, notably the eschar and enlarged lymph nodes. Scrub typhus is a severe disease, complications are frequent, and it has a mortality rate of about 8 per cent to 10 per cent. Tick typhus, on the other hand, is always a mild disease. The etiologic agent of North Queensland tick typhus is different from a number of other rickettsial agents and may be a hitherto undescribed Rickettsia.

South African Medical Journal, Cape Town

20:461-496 (Aug. 24) 1946. **Partial Index**

Plague Survey of Ngamiland, Bechuanaland Protectorate, During Epidemic of 1944-1945. D. H. S. Davis.—p. 462.
*Treatment of Herpes Zoster with Contramine. D. N. Bengis.—p. 467.
Induction of Labor by Puncture of Membranes. J. O. E. Apthorp. —p. 469.
*Case of Severe Septic Wound of Left Lower Leg Treated with Small Deep Grafts. S. V. Humphries.—p. 472.

Treatment of Herpes Zoster with Contramine.—Contramine, an organic sulfur compound, has the formula diethylammonium-diethyl-dithio-carbamate. Bengis says that it was first used in the treatment of herpes zoster in 1943 by Hawkes, who found it effective not only in this condition but also in chickenpox. Bengis reviews the results of treatment with contramine in 16 cases of herpes zoster. The drug was given intramuscularly in doses of 0.125 Gm. per cubic centimeter. Since there was no guide as to the number of injections required, the pain which occurred with the onset of the herpes was used as the criterion. The drug was given every day until the pain had subsided, with a maximum of six injections. The treatment seemed to cut short the duration of pain and dry the lesions fairly rapidly. The response in older patients was less favorable. Contramine did not prevent the full development of the lesions. No toxic effects were observed, with the exception of nausea in the youngest patient. In only 1 patient was there postherpetic neuralgia. In this case the lesion was extensive, involving five dorsal segments.

Small Deep Grafts in Treatment of Septic Wound of Leg.—A youth aged 18 sustained a severe lacerated wound of the lower part of the left leg in a truck accident. The wound sloughed, with the discharge of copious pus. A raw area was left approximately 8 inches long by 4½ inches wide. This was treated twice daily with gauze soaked in diluted solution of sodium hypochlorite with the object of rendering the surface aseptic. Two short courses of penicillin were given, one just after the wound sloughed, the second just after skin grafting. The grafts were removed from the outer surface of the thigh by means of a needle and scalpel. The grafts were transferred to the raw area on the tip of the needle and were pressed into place. Over 100 grafts were used, these being placed from ¼ to ⅙ of an inch apart. Perforated oil silk was used to cover the grafts, and the whole was covered with gauze wrung out in isotonic solution of sodium chloride. The entire wound had healed less than two months later. This case is noteworthy, says Humphries, because of the taking of grafts over so large an area, which was far from aseptic, and because of their survival in spite of the development of frank sepsis.

Nederlandsch Tijdschrift v. Geneeskunde, Amsterdam

90:799-838 (July 13) 1946. **Partial Index**

Experiences with Gamma Globulin in Measles. S. van Creveld and G. A. Fehmers.—p. 800.
Treatment of Pseudarthrosis of Neck of Femur. C. P. van Nes.—p. 803.
*Pulmonary Changes in Patients with Furunculosis. T. J. J. H. Meuwissen and G. B. A. Schasfoort.—p. 807.
Strangulation of Penis. A. G. J. Hermans.—p. 810.

Pulmonary Changes in Patients with Furunculosis.—Meuwissen and Schasfoort studied 14 patients with furunculosis and detected pulmonary changes in 9 of them. Five of these 9 complained of fatigue and cough. The other 4 presented symptoms of septicemia. The necropsy of 2 of these 4 revealed small, subpleural staphylococcic abscesses. These foci are probably the result of hematogenic dissemination of staphylococci. The authors observed that the pulmonary changes sometimes persist longer than the furuncles, and they think the patients should be kept in bed until all pulmonary changes have subsided. Search for tubercle bacilli was negative. The authors think that in the after-war period pyodermias probably will be frequent and the possibility of pulmonary changes should be kept in mind.

Nordisk Medicin, Gothenburg

30:1085-1132 (May 17) 1946. **Partial Index**

Medical Problems in Aviation and Results. E. H. Christensen.—p. 1085.
Carrot Soup in Dyspepsia in Infants. P. Selander.—p. 1091.

Hospitalstidende

*Osteomyelitis After Intraosseous Infusion. T. Søndergaard.—p. 1093.

Hygiea

Myoplegia Kaliopenica. R. Berlin.—p. 1099.
Blood Values in Healthy Infants Treated with Iron. K. L. Möller and B. Vahlquist.—p. 1101.
Diagnostic Significance of Calcification of Heart Valves. L. Walk. —p. 1105.

Svenska Läkaresällskapets Förhandlinger

Possibility of Directing Certain Chemotherapeutic Agents to Definite Tissues. S. Helander.—p. 1106.
Surgical Treatment of Angina Pectoris. Inga Lindgren.—p. 1114.

Osteomyelitis after Intraosseous Infusion.—Søndergaard found only 1 case of osteomyelitis after intraosseous infusion in the literature (Behr). He reports 5 cases, 3 after intratibial infusion in infants and 2 after intrasternal infusion in adults. In 1 instance the complication was the probable cause of death and in another caused permanent injury to the growing zone of the bone. One child died of intercurrent disease and 1 is still under treatment; extensive destruction of the proximal growing zone in the tibia occurred in both. The fifth patient recovered after three months. Since, as a rule, intraosseous infusion is employed in weakened patients susceptible to infection, strictest asepsis and antisepsis must be observed. Technic and apparatus must allow the infusion fluid to be kept sterile, and there must be no air contamination. Prolonged infusion increases the risk of infection. Infusion fluid isotonic with the blood is advised. Bacteremia seems to be a contraindication. Intraosseous infusion should be given only when access to the veins is blocked or is difficult. The method presents so many advantages, especially in the pediatric clinic, that continued use with improved technic is thought justifiable. If in spite of all precautions the procedure is found to involve a certain risk of osteomyelitis, its justification will have to be reconsidered.

30:1173-1232 (May 31) 1946. **Partial Index**

Roentgen Diagnosis in Disk Prolapse. K. Lindblom.—p. 1173.
Apparatus for Intravenous Injection of Aminosol. F. Lidström and A. Wretlind.—p. 1177.

Finska Läkaresällskapets Handlingar

*Pale Granular Substance of Cell. I. Wallgren.—p. 1201.

Hygiea

Melanin Pigmented Tumors: Thirteen Cases of Malignant Melanoma (Melanomsarcoma) in Eye. A. Bergstrand.—p. 1213.
Types of Healing in Pulmonary Abscesses. A. Ekengren.—p. 1217.
Operative Treatment of Femoral Hernia, with Special Regard to Recurrence. O. Lindahl.—p. 1220.

Pale Granular Substance of Cell.—Wallgren has found in the cytoplasm and the nucleus of living cells a double granular system in a structureless basic substance. Pale granules occur abundantly as floating drops of liquid situated close to chromophil granules, which often come into contact with one another by thread shaped bridges but do not float over into the shifting pale drops. The chromophil drops are evenly distributed in the basic substance; the pale drops, which do not stain, appear more unevenly. In stained cells these drops are visible as unstained granules beside the stained granules. In dark field illumination the pale granular substance is seen distinctly because of its refracting ability, while the chromophil drops appear like dark round shadows. Chemical reactions carried out with the pale granules suggest that they may contain carbohydrate matter. They are demonstrable in places in the cell where especially lively chemical processes may be assumed to occur and are thought to serve as depots for chemical energy and to be important for the vital functions of the cell.

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Book Notices

Ophthalmology in the War Years. Edited by Meyer Wiener, M.D., Professor of Clinical Ophthalmology, Washington University School of Medicine, St. Louis, Missouri. Volume I (1940-1943). Cloth. Price, $13.50. Pp. 1,166. Chicago: Year Book Publishers, Inc., 1946.

This volume is the result of a request by the Subcommittee on Ophthalmology of the National Research Council for a review of the literature on ophthalmology in the war years. The author acted as editor in chief and supervised the work of the thirty-six associate editors among whom it was divided. An attempt was made to include all the important contributions in the English speaking countries, South America and Europe. As a result of the exigencies of the war, the abstracts on the European literature, especially from Germany, are necessarily meager. Over eight thousand (8,286) articles have been abstracted or included in the bibliography.

The basic and fundamental sciences, such as anatomy and embryology, biochemistry, pharmacology and toxicology, comparative ophthalmology, physiologic optics, electrophysiology, experimental and general pathology and bacteriology are reviewed in abstract form. Similarly the clinical and scientific advances involving every structure of the eye are detailed under such headings as aqueous humor, congenital anomalies, conjunctiva, cornea and sclera, the lens, lids and lacrimal apparatus, neuro-ophthalmology, ocular muscles, orbit, eyeball and sinuses, the pupil, retina and vitreous. There are also several individual chapters on color blindness, glaucoma, injuries, methods of examination, instruments and apparatus, refraction and accommodation, surgery of the eye, systemic diseases, therapeutics, trachoma and tumors.

As is inevitable in such a work, composed of the efforts of many varied talents, some chapters are more adequately covered than others, depending on the talents and abilities of the individual authors. The volume covers an immense amount of work and will no doubt be useful to those engaged in research and writing. It will probably be of limited value to the average clinical ophthalmologist in spite of the immense amount of information that it contains. The editor in chief is to be commended for compiling such a valuable work during such arduous times as the war years.

Progress in Neurology and Psychiatry: An Annual Review. Edited by E. A. Spiegel, M.D., Professor and Head of the Department of Experimental Neurology, Temple University School of Medicine, Philadelphia. Cloth. Price, $8. Pp. 708. Grune & Stratton, Inc., 442 Fourth Ave., New York 16, 1946.

This is the first of a new series of annual reviews contemplated by its editor, whose aim it is to report on the progress made in the fields of neurology and psychiatry. To insure a semblance of cohesion and evaluation of the material offered, the editor invited a number of distinguished specialists, actively engaged in their various specialties, to cull the literature for any significant contributions and trends and to report their findings. The result is more than abstract service, for it is also a critical survey of the sciences involved. The latter fact justifies the work and makes it a valuable reference tome to the practicing neuropsychiatrist.

Interesting is the fact that out of 695 pages only 155 are devoted to psychiatry, whereas neurology is amply covered in 540 of the closely typed pages.

New Drugs. By Arthur D. Herrick. With foreword by Austin E. Smith, M.D., Secretary, Council on Pharmacy and Chemistry of the American Medical Association, Chicago. Cloth. Price, $4. Pp. 303. Revere Publishing Company, 11 Stone St., New York 4, 1946.

The tremendous scientific advances of the last ten years and the increasing complexity of pharmaceutic manufacturing and marketing make it difficult for people in the pharmaceutic manufacturing industry to keep adequately informed. Their tasks and responsibilities have also been greatly increased by the drug legislation passed in 1938 and the hundreds of regulations and rulings which have been made by various governmental agencies and bureaus since that time. To aid pharmaceutic manufacturers, professional advertising agency personnel and many others connected in one way or another with the business of developing and marketing pharmaceutic and biologic products, Arthur D. Herrick has written this invaluable book. In addition to tracing the history of new drug legislation and explaining its background and general application, Herrick covers comprehensively and with sufficient detail such matters as components and composition, labeling and samples and investigations to determine safety and effectiveness. He also outlines the proper methods for applying for approval to market new drugs and provides practical instructions for the person who must act as the contact between his firm and various governmental agencies. The book also includes an appendix giving the history of the elixir sulfanilamide fiasco and another including the Federal Food, Drug and Cosmetic Act and regulations.

The Management of Obesity: A Handbook for the General Practitioner. By Louis Pelner, M.D. Cloth. Price, $3. Pp. 144, with illustrations. Personal Diet Service, 145 W. 45th St., New York 19, 1946.

This book has been designed for the general practitioner as a guide in the practical management of obese patients. In this effort the author, perhaps wisely, included a minimum of physiologic and pathologic data, avoided controversial views in etiology and diagnosis and applied a number of simplified illustrations, food charts, diet lists and low caloric menus. The principles and details of treatment as expressed by the author are, on the whole, sane and in good accordance with present knowledge. This book should serve well the general practitioner in solving important problems in his daily practice.

L'anémie infectieuse. Par G. Hemmeler, chef de Clinique médicale universitaire Lausanne, Switzerland. Paper. Price, 5 Swiss francs. Pp. 76, with 11 illustrations. Benno Schwabe & Co., Klosterberg 27, Basel 10, 1946.

This little paper-covered book is concerned with the anemia of infection, in which there has been relatively little interest, although a few authoritative articles, notably from Wintrobe's clinic, have recently appeared. The object of the present work is to study the frequency of infectious anemia, the changes in blood and bone marrow, the pathogenetic mechanisms and finally therapy. It was found that most febrile diseases resulted in anemia, most pronounced in cases showing the greatest elevations in temperature, sedimentation rate and leukocytosis. A series of 25 cases is presented in which careful studies of the blood morphology and the sternal bone marrow were made. These showed a normochromic hypoplastic type of anemia due to a lack of erythroblastic maturation. Serum iron studies gave low values, indicating that the anemia was "toxic" in type with a direct disturbance in erythropoiesis. It was found that transfusions of blood represented the only valuable method of therapy of the anemia.

This monograph can be recommended as a clear, straightforward account of most of our available knowledge of the anemia in infection and should help to fill the gap which the author says exists in the description of this common and therefore important field. The author probably did not have access to the comprehensive study by Dr. Gulli Lindh Muller of the blood in tuberculosis (Commonwealth Fund, 1943).

Libido and Delusion. By Louis S. London, M.D. Second edition. Cloth. Price, $3.50. Pp. 259. Mental Therapy Publications, 1150 Connecticut Ave., Washington 6, D. C., 1946.

Psychiatric and psychoanalytic writing is often difficult to read and confusing; this book is incoherent, unintelligible and filled with incorrect assertions. After presenting 353 sessions of analysis of a schizophrenic, covering 100 pages of incomprehensible material, the author says "this case is not reported as a therapeutic success. It merely shows that some cases of schizophrenia can be analyzed as successfully as cases of neuroses."

Men, Mind and Power. By David Abrahamsen, M.D., Department of Psychiatry, Columbia University, New York. Cloth. Price, $2. Pp. 155. Columbia University Press, 2960 Broadway, New York 27, 1945.

In a rather disorganized fashion the author presents a mixture of ideas concerning the psychologic forces underlying the behavior of the German people in general and the Nazis in particular. Some of the ideas are naive, others penetrating. The general presentation is often confused. The book is a far cry from the detailed and systematic study which is a prerequisite to an enduring contribution on this subject.

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Queries and Minor Notes

THE ANSWERS HERE PUBLISHED HAVE BEEN PREPARED BY COMPETENT AUTHORITIES. THEY DO NOT, HOWEVER, REPRESENT THE OPINIONS OF ANY OFFICIAL BODIES UNLESS SPECIFICALLY STATED IN THE REPLY. ANONYMOUS COMMUNICATIONS AND QUERIES ON POSTAL CARDS WILL NOT BE NOTICED. EVERY LETTER MUST CONTAIN THE WRITER'S NAME AND ADDRESS, BUT THESE WILL BE OMITTED ON REQUEST.

BOOSTER DOSES OF TETANUS TOXOID AND TYPHOID VACCINE

To the Editor:—Two brothers aged 7 and 5 years each received 2 cc. of tetanus-diphtheria toxoid (Lilly) at three months intervals in 1945. One boy has eczema. Should they be given booster doses of tetanus toxoid and, if so, when? What is the dosage of typhoid vaccine, both subcutaneous and intradermal, if administered as a booster dose at yearly intervals?

J. J. Johnson, M.D., Las Vegas, N. M.

ANSWER.—Since the children described in the query were inoculated with tetanus-diphtheria toxoid in 1945, it is not necessary to administer additional material at present except in the event of injuries likely to lead to the development of clinical tetanus. The indications for such an injection would be Fourth of July accidents, penetrating wounds, dirty lacerations, severe burns, compound fractures, severe crushing injuries and lesions of any type with possible contamination with soil. The booster dose of tetanus toxoid need not be large. Thus, doses of 0.1 cc. or less induce prompt rises, of adequate level and duration, in the antitoxic titers of those inoculated as long as five years previously with tetanus toxoid alone or in combination with diphtheria toxoid (McBryde, Angus, and Poston, M. A.: *J. Pediat.* **28**:692 [June] 1946). The material may be given either intradermally or subcutaneously, and either fluid or alum precipitated tetanus toxoid may be used, individually or in conjunction with other antigens.

The problem of typhoid booster doses, given at yearly intervals, is essentially the same as that of tetanus. A minute dose of typhoid vaccine, preferably by the intradermal technic, will promptly restore active immunity to this disease. The dose should be 0.1 cc. of that dose which was associated with minimal, or no, constitutional reaction during basal immunization. In case no reaction appeared during the original series, it is desirable to use 0.1 cc. of the third strength used initially.

IMMUNIZATION OF ALLERGIC CHILD

To the Editor:—A boy aged 8 years has received injections for allergy for the past two years. He has not been immunized. His mother wishes to know if the usual childhood immunization measures would be safe, including smallpox, diphtheria and tetanus.

M.D., Michigan.

ANSWER.—If the patient's allergic condition does not include eczema at this time there is no contraindication for immunization with smallpox vaccine. Usually patients who are allergic tolerate, without difficulty, diphtheria toxoid and tetanus toxoid as well as immunization with vaccines such as pertussis vaccine. Occasionally in patients younger than 8 years who are allergic, one encounters a local swelling together with a rise in temperature and general malaise following the first dose of diphtheria toxoid, tetanus toxoid or pertussis vaccine. To avoid the possibility of this type of unusual reaction it may be advisable to reduce the first dose by one half. This precaution, however, is not usually followed, because of the infrequency of such an untoward reaction. Should a general reaction occur, the next dose of the vaccine or toxoid should be reduced and given only after all local swelling and itching have disappeared from the site of the previous injection.

POTENCY STANDARDS OF TESTOSTERONE

To the Editor:—What is the relation between capon units and milligrams in reference to testosterone?

M.D., Illinois.

ANSWER.—The capon unit employed in the biologic standardization of certain androgenic preparations is not applicable to products of definite composition, such as testosterone, the dosage and potency of which may be expressed in terms of weight. Some idea of the comparative potency of a product standardized in terms of capon units and a product representing a given weight of testosterone may be obtained from the following figures received from a competent investigator in the endocrine field: The international unit of androgenic activity is equivalent to 0.1 mg. of crystalline androsterone, 1 capon unit is equivalent to 1.5 international units and 1 mg. of testosterone propionate represents approximately 50 international units, or about 32 capon units.

POSSIBLE PAGET'S DISEASE

To the Editor:—One year ago while in a summer camp a girl aged 17 years developed an eczematous eruption about the nipples, with redness, itching, burning sensation and secretion. At this time she had a high temperature, and the breasts were hard and inflamed. Penicillin was administered parenterally and boric acid compresses were applied to the breasts. The condition subsided and the patient remained well for one year, until there was a recurrence at camp this summer. Please discuss the probable diagnosis, prognosis and treatment recommended.

Hyman Rappaport, M.D., Corona, N. Y.

ANSWER.—It is, of course, difficult to make a dermatologic diagnosis without the opportunity of seeing the patient, but as a general rule any recurrent eczema of the nipple should be looked on with suspicion and the possibility of Paget's disease considered. This does not mean that every eczema of the nipple is Paget's disease; however, if an eczematoid-like eruption about the nipple of a girl aged 17 does not respond to local applications or if there is a tendency for skin lesions to involute and recur repeatedly, a biopsy should be considered.

The essential lesion of early Paget's disease of the nipple is the atrophy of the nipple itself, a significant clinical finding. X-ray therapy should be avoided until a definite diagnosis is made. It might well be that the secondary infection present in the breasts last summer was made possible by the presence of the dermatosis.

Paget's disease of the nipple may manifest itself primarily as an intraductal carcinoma or it may start as a squamous cell epithelioma in situ of the nipple with secondary involvement of the breast tissue.

CARE OF PREMATURE INFANTS

To the Editor:—What is the chief cause of death of premature infants? Should vitamin K and Ringer's solution be used routinely? Does vitamin K affect the vessel or just the coagulation of the blood?

Homer D. Hoskins, M.D., Oceanside, Calif.

ANSWER.—While immaturity is the most frequent cause of death among premature infants, intracranial hemorrhage ranks second as the most common pathologic complication. In one premature station, vitamin K by hypodermic administration is now given to all premature infants. In most instances one administration, given as early as possible in the amount of 2 mg., is the usual procedure. The effect of vitamin K is dependent on its effect on coagulation of the blood. Isotonic solution of sodium chloride or isotonic solution of three chlorides is administered subcutaneously in amounts ranging from 8 to 30 cc. or more two or more times daily to infants who cannot be fed a sufficient amount of fluids by mouth. The administration of oxygen, preferably in a closed chamber, is the routine procedure in the care of all small premature infants. The larger ones are left in the chamber for one day; the smaller infants may require one or more weeks. The oxygen content in most instances averages about 40 per cent, double that of atmospheric oxygen, which is 20 per cent. The infant's temperature should be maintained above 96 F. by supplying external heat.

CANCER HEREDITY IN MICE

To the Editor.—I understand that in mice hereditary cancer can be bred in succeeding generations. Can you tell me whether any one has ever tried to implant the cancer of the mature mouse into the young offspring before the latter becomes of cancer age and thereby perhaps build up cytolysins or other antibodies that might inhibit the growth of the cancer when the mouse does become of age?

M.D., Pennsylvania.

ANSWER.—Mice can be bred in such pure strains that nearly all develop cancer of some specific type. A number of experiments have been done in which the cancer of the mature mouse has been implanted in young animals before their cancer age was reached. Antibodies can be demonstrated to be developed, but they are weak and irregular. Furthermore, they appear to have little influence on the progression of cancer when it develops spontaneously. The recent work of J. J. Kidd at the Cornell University Medical College and of R. G. Green at the University of Minnesota bears on this point.

INTRAMUSCULAR AMINOPHYLLINE

To the Editor:—Many physicians avoid the use of aminophylline 7½ grains (0.5 Gm.) intramuscularly because of the pain involved. This medication is a valuable addition to the asthmatic drug armamentarium. The simultaneous injection of equal parts of procaine hydrochloride 1 or 2 per cent in each of the deltoid areas of the arms causes little discomfort and will bring about an aminophylline effect in twenty to thirty minutes.

Robert R. Schwartz, M.D., Bronx, N. Y.

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SUBJECT INDEX

This is an index to all the reading matter in THE JOURNAL. In the Current Medical Literature Department only the articles which have been abstracted are indexed.

The letters used to explain in which department the matter indexed appears are as follows: "BI," Bureau of Investigation; "E," Editorial; "C," Correspondence; "OS," Organization Section; "ab," abstracts; the star (*) indicates an original article in THE JOURNAL.

This is a subject index and one should, therefore, look for the subject word, with the following exceptions: "Book Notices," "Deaths," "Medicolegal Abstracts" and "Societies" are indexed under these titles at the end of the letters "B," "D," "M," and "S." State board examinations are entered under the general heading State Board Reports, and not under the names of the individual states. Matter pertaining to the Association is indexed under "American Medical Association." The name of the author, in brackets, follows the subject entry.

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Acad.—Academy *Indust.—Industrial*
Am.—American *Inst.—Institute*
A.—Association *Internat.—International*
Coll.—College *M.—Medical*
Comm.—Commission *Med.—Medicine*
Comm.—Committee *Nat.—National*
Conf.—Conference *Pharm.—Pharmaceutical*
Cong.—Congress *Phys.—Physicians*
Dist.—District *Soc.—Society*
Div.—Division *Surg.—Surgery*
Found.—Foundation *Surgs.—Surgeons*
Hosp.—Hospital *S.—Surgical*

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